Thalassemia Clinical Data Sheet

For Thalassemia/Hemoglobinopathy Phenotype Work-up

Forward this form directly to Red Cell Disorders lab

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Phone (206) 744-3549
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Print Clear

*Patient Name (Last name, first name, middle): _____

Referring Medical History No. _____

*Referring Physician: _____ Physician's phone #: _____

*Date of birth: _____ Age: _____ *Sex: ☐ Male ☐ Female

*Is patient pregnant: No ☐ Yes ☐ EDD: _____

*Ethnic Background: _____

Please be as explicit as possible; e.g. if patient is Caucasian, is (s)he an ethnic Mediterranean (Greek, Italian); if Asian, is (s)he Cambodian, Laotian, Korean, North/South Chinese, etc.

Pertinent Family History:_____

Lab Results: ☐ Lab Data Attached OR ☐ Fill in below

***CBC**

Hb _____ Hct _____ MCV _____ MCH _____ MCHC _____

date performed: _____

* Information is required to complete the thalassemia work-up.

Pediatric patients only

Washington State Dept. of Health Newborn Hb screen result _____

Fe Studies

Is patient currently receiving iron therapy?

☐ Yes ☐ No

Has patient received a blood transfusion within the past 4 months?

☐ Yes ☐ No

Test	Result	Reference Range	Unit	Date Drawn
FE				
TIBC				
%Sat.				
Ferritin				

Results need to be within the past month

Completion of the above information will assist us in reflexive testing pathway selection and interpretation of the results. This information is particularly useful in screening for hemoglobinopathies and thalassemia because test results for these disorders are influenced by one or more of the factors listed above.

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