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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*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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