UR MEDICINE | Labs

# Specimens:			Depot:	
Collect Date:	Time:	By:	ABN Signed: ☐	***STAT***
MR #:		A #:		

REQUIRED (PRINT OR PATIENT LABEL)

Name(Last, First, MI)

Date of Birth | Sex:(circle) M F

Street Address

Street Address 2

City, State, Zip

Phone Number | Chart Number

Phone Results to: Fax Results to:

Ordering Provider's Signature
Date of Signature

Diagnosis Mandatory: Signs/Symptoms or ICD10 Codes
If ordered for screening, list test name here and write "SCREENING" after it

Send Additional Reports To: (Full Name/Address)

Compliance is Mandatory and Regulated. For the laboratory to bill properly and receive payment for tests ordered on Medicare Beneficiaries, specific ICD-10 code(s) or a descriptive diagnosis must be included on each patient for each test ordered.It is critical that the diagnosis provided to the lab is consistent with those recorded in the patient medical record on the date of service.

23130 ☐ **(HBE) Hemoglobin Electrophoresis**

☐ **Additional confirmatory testing (Sickle cell solubility test, Acid Hgb electrophoresis) not needed**

Transfusion History:

Date of last transfusion:

PATIENT CONSENT (only for initial diagnosis)

I have read the information on the back of this form and discussed it with my health care provider. I have been given the opportunity to ask questions and have them answered about the tests ordered. I authorize collection and analysis of the necessary sample(s).

Patient/Legal Guardian: Date:

HEALTH CARE PROVIDER CONSENT

I attest that I have reviewed the requirements for genetic testing ordered on the requisition with the patient. I have conveyed the required information to the patient. I have conveyed the required information to the patient and obtained consent.

Health Care Provider: Date:

Hemoglobin Electrophoresis Testing

Patient Information Sheet

UR Medicine
University of Rochester/Strong Memorial Hospital Clinical Laboratories
601 Elmwood Avenue; PO Box 608; Rochester, NY 14642

This test looks for changes in gene products that are known to be associated with risk of specific diseases. The purpose of these tests is to help your provider more accurately diagnose your current condition and/or future risk of disease for offspring.

In addition to assisting in making a diagnosis, these tests may reveal a genetic pre-disposition for one or more of these diseases. You may wish to get genetic counseling before consenting to this test. If a positive result is obtained, additional testing and/or genetic counseling follow-up may be advised.

Your provider has ordered the following test:

Hemoglobin Electrophoresis (HBE) - This is a test for the diagnosis or treatment of diseases involving abnormal forms of hemoglobin, such as the beta chain variant associated with sickle cell disease and the abnormal percentage of otherwise normal hemoglobin associated with alpha- and beta- thalassemia.

If ordered, additional testing may be performed to confirm the initial finding of a variant hemoglobin.

The results of this screening test assists in diagnosis, but do not by themselves permit diagnosis of a disease condition. This testing is ordinarily highly accurate; however, in some cases results may not be obtained or may be inconclusive.

Because interpretation of genetic test results is complex, the test results will be provided to your provider who will inform you of the results. To the extent permitted by law, all of the records and results of this testing are confidential and will not be released to anyone other than you, your referring providers, and Strong Memorial Hospital Medical Records without your consent.

I understand that a biologic specimen (blood) will be obtained from me and/or members of my family.
I understand that this biologic specimen will be used for the purpose of attempting to determine if I and members of my family are carriers of the disease gene, or are affected with, or at increased risk to someday be affected with this genetic disease.

No tests other than those authorized will be performed on your sample. Your sample will be destroyed after testing in accordance with our sample retention policy, not more than sixty days after the collection of the sample.