

HEMOGLOBIN ELECTROPHORESIS—WHOLE BLOOD

N.C. Department of Health and Human Services
 State Laboratory of Public Health
 4312 District Drive
 Raleigh, NC 27607

Lab Use Only	<input type="checkbox"/> Acceptance Criteria Not Met <input type="checkbox"/> Inappropriate temperature <input type="checkbox"/> Specimen too old <input type="checkbox"/> Incomplete labeling/form <input type="checkbox"/> Specimen inappropriate/damaged Date: ____/____/____ Initials: ____
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Please Give All Information Requested

Attach Printed Label Below

Patient Information	Last Name				
	First Name		MI		
	Maiden Name/Surname				
	Address/Attention:				
	Street Address:		Address 2:	City:	
	State:	Zip Code:	County Code:	County Name:	Phone Number:
	Insurance ID Number: (if applicable)		Medicaid Number (if applicable):		
	Medical Record Number:		Date of Birth: ____/____/____	If Female, Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Transgender M2F <input type="checkbox"/> Female <input type="checkbox"/> Transgender F2M <input type="checkbox"/> Unknown <input type="checkbox"/> Transgender Unknown <input type="checkbox"/> Ambiguous		Race (mark all that apply): <input type="checkbox"/> White <input type="checkbox"/> American Indian/ <input type="checkbox"/> Black <input type="checkbox"/> Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/ <input type="checkbox"/> Unknown <input type="checkbox"/> Pacific Isles		Ethnicity: <input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown
	Blood Transfusion Within 4 Months? If yes, record date: ____/____/____				
Submitter	EIN: _____-____		Submitter Name:		
	Address:		Address 2:	City:	
	State:		Zip Code:	County Name:	
	Phone Number:		Email Address:	Fax Number:	
	Ordering Provider NPI:		Ordering Provider First and Last Name:		
Specimen	Collection Date: ____/____/____	Collection Time: ____:____	24 Hr Time Collector's Initials		
	Specimen source: Whole Blood		Reason for Testing (ICD-10 Dx Code): _____		
	Test ordered: <input type="checkbox"/> Family Study <input type="checkbox"/> Follow Up Testing		Laboratory Number: <i>Do Not Write in this Space</i>		
Other	Is this patient: <input type="checkbox"/> Original Patient or <input type="checkbox"/> Mother <input type="checkbox"/> Sibling <input type="checkbox"/> Father <input type="checkbox"/> Partner/Spouse of original patient		Original Patient's Name: _____ Date of Birth: ____/____/____ Original Lab Number: _____		

Note: For family study specimen submission, provide the original laboratory number, original name as submitted for newborn screening and date of birth of the infant.