HEMOGLOBIN ELECTROPHORESIS—WHOLE BLOOD

N.C. Department of Health and Human Services
State Laboratory of Public Health
4312 District Drive ● P.O. Box 28047
Raleigh, NC 27611-8047

Please Give All Information Requested *Attach Printed Label Below*

Patient Information

Last Name			(label area)	
First Name		MI		
Maiden Name/Surname				
Address/Attention:				
Street Address:			Address 2:	City:
State:	Zip Code:	County Code:	County Name:	Phone Number:
SSN: __ __ __/__ __/__ __ __ __			Medicaid Number (if applicable): __ __ __ __ __ __ __ __ __ __	
Medical Record Number:		Date of Birth: __ __/__ __/__ __ __ __		If Female, Pregnant? ❑ Yes ❑ No ❑ Unknown
Sex: ❑ Male ❑ Female ❑ Unknown ❑ Ambiguous ❑ Transgender M2F ❑ Transgender F2M ❑ Transgender Unknown		Race (mark all that apply): ❑ White ❑ Black ❑ Asian ❑ Unknown ❑ American Indian/ Alaska Native ❑ Native Hawaiian/ Pacific Isles		Ethnicity: ❑ Hispanic or Latino Origin ❑ Non-Hispanic ❑ 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: __ __/__ __/__ __ __ __	Collector's Initials
Specimen source: Whole Blood	Reason for Testing (ICD-10 Dx Code): __ __ __ __ __ __ __
Test ordered: ❑ **Family Study** ❑ **Follow Up Testing**	Laboratory Number: *Do Not Write in this Space*

Other

Is this patient: ❑ Original Patient or ❑ Mother ❑ Sibling ❑ Father ❑ 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.