HEMOGLOBIN ELECTROPHORESIS—WHOLE BLOOD

Lab Use Only

☐ **Acceptance Criteria Not Met**
- ☐ Inappropriate temperature
- ☐ Specimen too old
- ☐ Incomplete labeling/form
- ☐ Specimen inappropriate/damaged

Date: ____/____/_____ Initials:_____

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

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? ☐ 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: ____/____/____ Collection Time: ____:____ 24 Hr Time | 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.