NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

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Executive Deputy Commissioner

Informed Consent for Sickle Cell Carrier Screening

1. The purpose of this testing is to determine if I am a carrier for sickle cell disease, also known as sickle cell trait. If two people with sickle cell trait have children, there is a 25% chance for each child to have a serious medical disorder, sickle cell disease. Very rarely, people with sickle cell trait can have symptoms during times of extreme physical stress and/or dehydration.

2. This testing is done on a small sample of blood applied to a filter paper.

3. This test looks for the abnormal hemoglobin molecule in the blood.

4. Possible outcomes of this test are:
    a. Screen negative (You are not a carrier for sickle cell disease)
    b. Sickle cell trait
    c. An abnormal hemoglobin identified in the blood other than sickle cell trait

5. If sickle cell trait or another abnormal hemoglobin molecule is identified, genetic counseling, further testing or additional physician consultations may be recommended.

6. Testing may be recommended for family members. Testing of family members could discover evidence of previously undisclosed non-paternity.

7. The results of this test will only be released to the ordering physician below.

8. After the testing is complete, a portion of the blood may be used for public health research.
    - I agree to allow my blood sample to be used for public health research: _____ (Initial)
    - I prefer to have my sample destroyed within 60 days of collection: _____ (Initial)

_____ _____ _____
Patient Name (please print) Date of Birth Hospital of Birth

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian (if patient under 18) Date

I attest that I am the physician of record who is providing medical care for this individual and I have reviewed this consent form with them and I have offered genetic counseling prior to having this test.

_____ _____
Physician Signature Date

_____
Physician License Number

_____
Physician Address

_____ _____
Physician Fax Physician Phone Number