OKLAHOMA STATE DEPARTMENT OF HEALTH - CHILD/ADULT SICKLE CELL SCREENING

Patient's Last Name | First Name | For State Health Dept. Use Only

M M - D D - Y Y Date of Birth | M M D D Y Y Collection Date

Sex ☐ Female ☐ Male

TEST REQUESTED:

☐ Initial HGB

☐ Repeat HGB

Previous Lab Number

Race / Ethnic ☐ 1. White ☐ 2. Black ☐ 3. Hispanic ☐ 4. Asian ☐ 5. Indian ☐ 6. Other

For State Health Use Only:

If patient is a minor, list head of household

Last Name, First Name

Patient's Social Security #

Ser. No. S 012955

Address

City | OK | Zip Code - Ext.

Provider / Submitter ID#

Name:

Address:

City/St./Zip:

( )- - Telephone or Contact #

Provider's ID | Provider or Physician's Last Name & Initials

( )- - Provider or Physician's Telephone

L-8224197