



Albany
Medical
Center

***Testing for Hemoglobin S and C
and for Overproduction of
Hemoglobin A₂ and F***

MR#:

PATIENT NAME:

DATE OF BIRTH:

SEX:

DATE OF SPECIMEN COLLECTION:

REQUESTING PHYSICIAN:

Attestation for Quantitative Hemoglobin Fractionation Testing

I am the physician counseling the patient named above. I have informed the patient of the nature and limitations of this test and have obtained the patients consent for the genetic test named above.

Signature of Physician or other authorized person required

Date

***Include this attestation with the specimen at the time of collection, OR
Fax to 518-262-8257, Special Chemistry Lab***