Sickle Cell Test Results Request Form

Please provide the following information for athletes requiring sickle cell trait test results. Results will be faxed or securely emailed to your pediatrician/primary care provider within five business days of this request. If it has been more than five business days and they have not arrived, please contact the Newborn Screening Nurse Coordinator at 401-921-7619.
Fax this form to 401-222-5688.

Contact Information for Person/Athlete Requiring Sickle Cell Trait Test Results

First Name _____

Last Name _____

Phone Number (Include Area Code) _____

Date of Birth _____

At the time of Athlete's birth, what was the mother's name?

Mother's First Name _____

Mother's Last Name _____

Pediatrician/Primary Care Provider (PCP) Information

Pediatrician/PCP's Name _____

Pediatrician/PCP's Office Name _____

Pediatrician/PCP's Office Phone Number _____

Please provide **either a fax number or an email address**. If the PCP prefers email, results will be securely emailed.

Pediatrician/PCP's Office Fax Number _____

Pediatrician/PCP's Email Address _____