Rhode Island Newborn Screening Program
Rhode Island Department of Health
3 Capitol Hill, Room 302
Providence, RI 02908
401-222-5924 (office)
401-222-5688 (fax)

SICKLE CELL REQUEST FORM FOR STUDENTS BORN IN RHODE ISLAND

NOTE: If you were not born in Rhode Island, please contact the Newborn Screening program in the Health Department of the state in which you were born.

The NCAA requires college athletes to provide proof of their sickle cell trait status. Primary care providers may order sickle cell testing or can refer patients to private labs. Students may be tested at any laboratory that offers sickle cell solubility testing.

RESULTS WILL BE PROVIDED WITHIN 5 BUSINESS DAYS.

Student/patient name: Birth order (if one of multiple births):

Mother's full name at time of student's birth:

Date of birth: Hospital of birth:

Please check appropriate box for preferred transmission method: ☐ Secure email (log into web-based system) ☐ Fax

Please send sickle cell trait screening results to: ☐ Student (if 18 or older) ☐ Parent (if under 18) ☐ Medical provider

Please send report to the following email address OR fax (please indicate only one):

Phone number for follow-up questions:

IF YOU ARE A STUDENT WHO IS 18 OR OLDER OR THE PARENT OF A STUDENT YOUNGER THAN 18 & WANT THE REPORT SENT TO YOU, STOP HERE & FAX TO 401-736-4274 OR 401-222-5688.

Medical Providers: By making this request, you certify that you are the current healthcare provider for the patient listed above. This section of the form is NOT to be used for releasing results to health centers affiliated with a school. It is ONLY to be used for the student/patient's primary care provider.

Practice Name: Attn:

IF YOU ARE A MEDICAL PROVIDER, STOP HERE AND FAX TO 401-736-4274 OR 401-222-5688.

College/University Health Center: This section of the form should be used only if the student athlete does NOT have a primary care provider and does not want to receive results. Results will be sent to the student athlete's health center at their college/university. RIDOH cannot share information directly with coaches.

If any sections are left blank, permission will be considered not valid, and we will not be able to share information with the person(s) or organization you listed on this form.

Student's current phone number:
Student's current e-mail address:

I request and authorize the Newborn Screening Program to release sickle cell disease/trait test results for the patient named above to the following **College or University Health Center**:

Attention: **Name:**
Street Address: **City, State, Zip Code:**
Phone #: **Fax #:**
Email address:

Please (check only one) send results via Fax ☐ OR via secure email ☐.

I understand that by voluntarily completing this authorization and/or request to release this information, my medical record information may be shared via fax or mail. I understand that sensitive health information may be shared and that I have the right to revoke my consent at any time. I also understand that revoking my consent to share my health information does not apply to information that was shared while this authorization and/or request to release information was previously in effect. I understand that a photo scan or faxed copy of my authorization and/or request to release this information is as valid as the original.

_____ _____

Student Signature **Date**

_____ _____

Witness Signature **Date**