NSI Package Checklist

Initial in all boxes to certify that the MANDATORY documents are contained in your NSI submission package. Affix this page to the top of your package and mail to the address below.

JRD	New Student Indoctrination Information Sheet
JRD	NROTC Standard Release Form
JRD	Authorization for Disclosure of Medical or Dental Information (DD Form 2870)
JRD	American Academy of Family Physicians Preparticipation (Sports) Physical Evaluation History AND Physical Examination Forms, 2019 version (Must use this 4 page document)
JRD	List of ALL prescriptions and over the counter medications (make sure you include this on your sports physical)
JRD	List of all allergies, reactions, and EpiPen (make sure you include this on your sports physical)
JRD	Copy of immunization record with documentation of the six (6) following vaccines:
JRD	*One Dose of Quadrivalent Meningococcal Vaccine (for example MCV vaccine) on or after 16th birthday
JRD	*Two Doses of Mumps, Measles, Rubella (MMR) Vaccine at least 28 days apart
JRD	*Two Doses of Varicella (Chicken Pox) Vaccine or Titer Test From Lab Documenting Immunity
JRD	*One Dose of TDaP Vaccine within the last 10 years
JRD	***There is NOT a mandatory COVID-19 Vaccine Requirement, per the 2023 National Defense Authroization Act (NDAA). However, it is HIGHLY RECOMMENDED that students arrive fully vaccinated due to the close living accomadations at RTC and the high transmissibility of COVID-19. It is MANDATORY that you inform us of your vaccination status because there may be future protocols developed to protect the health of personnel that are not vaccinated and the readiness of military personnel.*** For your reference, to be considered fully vaccinated a person must have received one of the following vaccine protocols; At least one dose of Janssen ***or*** two doses of either Pfizer, Moderna, or Novavax COVID-19 Vaccine. If you are vaccinated, please include proof with your vaccination records.
JRD	*Seasonal Influenza
JRD	Sickle Cell Solubility Lab Test results (Hb S, Hemoglobin S, Hgb Solubility, Sickle Cell Preparation, Sickle Cell Test, and Sickle Prep are all common names for the test we require). Provider notes stating a student's Sickle Cell Trait status WILL NOT be accepted, send only lab results.

Mailing Address:

Naval Service Training Command
Attn: Candidate Midshipman Guidance Office (CMGO)
320A Dewey Ave, Building 3, Room 106
Great Lakes, IL 60088-2911

Candidate Signature John R. Doe

2023 NEW STUDENT INDOCTRINATION (NSI) INFORMATION SHEET

Please fill in legibly. All fields ARE REQUIRED in order to register students in our training and health care systems prior to the start of training.

Last Name: Doe First Name: John Middle Initial: R

Full Social Security Number: 123-45-6789 Date of Birth: 11/13/2004

Place of Birth: Friendship, ME Marital Status: Single

Ethnicity: Caucasian Religious Preference: No Religious Preference

Email Address: Johndoe2004@yahoo.com

Home of record (Usually Mother/Father's address):

123 Crabapple Lane Friendship, ME 04547
(Number and Street Name) (City, State, Zip Code)

Cell Phone #: (207) 555-0001 Resident Phone #: (207) 555-0002

Father's Full Name: Edgar Allan Doe

Father's Contact Phone #: (207) 555-0003

Mother's Full Name (Include Maiden Name): Jane Ann Smith Doe

Mother's Contact Phone #: (123)456-7890

OPTION: Navy, Nurse, or Marine Corps (circle one)

School approved for or school you plan to attend: University of San Diego

Gender (used for berthing purposes): Male

Date of High School Graduation: 06/02/2023

Do you have any commitments that prevent you from attending any of the NSI training iterations? If so, which dates are you unavailable?

I have a family vacation during NSI 1. I have a committment at UCSD during NSI 2.

NSI 3 will work best for me.

DoD Identification Number (for military dependents only): _____

Midshipman Candidate Signature: John R. Doe Date: 11/14/2022

NAVAL RESERVE OFFICERS TRAINING CORPS (NROTC) STANDARD RELEASE FORM AND PRIVACY ACT NOTIFICATION

I, John R. Doe, a Candidate of the Naval Reserve Officers Training Corps, in consideration of basic participation in Naval Reserve Officers Training Corps sponsored extracurricular activities, to wit NROTC New Student Indoctrination from 8 June to 7 August 2023 do hereby release from any aud all claims, demands, actions, or causes of action, due to death, injury, or illness, the government of the United States and all its officers, representatives, and agents acting officially and also the local, regional, and national Navy Officials of the United States, except as provided under 10 USC 1074b.

I hereby authorize personnel of the Department of the Defense, Armed Forces, Public Health Service, or civilian physicians to render such medical and dental care as may be necessary and medically indicated in my case during this period of activity, as is deemed necessary by a qualified practitioner.

I understand that if I am injured in the line of duty during this training evolution that I may file a claim under the Federal Employee's Compensation Act (5 USC 8101 et seq.). The claim will be administered by the U.S. Department of Labor. If the claim is denied, I may be responsible for the cost of all medical care.

I understand that care at a military medical facility for non-military dependents will normally be rendered on a temporary (emergency) basis only; if further care is indicated, the patient will be transferred to non-military care as soon as possible. Emergency care provided to candidates who are not military dependents at a military medical facility may be subject to reimbursement, and I may be billed for the care provided. For Navy Medical Department facilities, such care is authorized by BUMED INSTRUCTION 6320.103.

I have no known medical conditions that might preclude or limit in any way participation in Naval Reserve Officers Training Corps sponsored extracurricular activities.

PRIVACY ACT INFORMATION

Under the authority of 5 U.S.C. Sec. 301, the information regarding your health, medical condition and treatment is requested in order to verify any need to administer medication and to enable medical/dental personnel to diagnose and treat any emergency condition that may arise during the above-mentioned activities. This information is protected under the Privacy Act, 5 U.S.C. 552. By signing this agreement, you agree that your medical information and other necessary information may be released to medical providers to provide for medical treatment. Disclosure is voluntary, however failure to provide the requested information will preclude your participation in the activity specified above.

In the event of an emergency, Navy personnel may contact the following individuals and discuss your medical condition:

Name: Jane A. Doe (Mother)

Address: 123 Crabapple Lane
Friendship, ME 04547

Telephone: (123) 456-7890

Email: Janedoe7@yahoo.com

Candidate Signature: John R. Doe

Printed Name: John R. Doe

Address: 123 Crabapple Lane
Friendship, ME 04547

Telephone: (207) 555-0001

CONSENT OF PARENTS (OR GUARDIANS)

(To be completed and notarized if the Candidate is under 18 years of age)

I certify that I am the parent or legal guardian of the Candidate who has signed this form in the above signature block.

I have read and understand this form.

I hereby consent to the Candidate's execution and participation in NROTC New Student Indoctrination program of this form.

Parent Signature: _____

Printed Name: _____

Address: _____

_____

_____

Telephone: _____

Prescribed by: DoDM 6025.18 CONTROLLED when filled

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME (Last, First, Middle Initial)	2. DATE OF BIRTH (YYYYMMDD)	3. SOCIAL SECURITY NUMBER
Doe, John, R	20041113	123-45-6789

4. PERIOD OF TREATMENT: FROM - TO (YYYYMMDD)	5. TYPE OF TREATMENT (X one)
20230608 to 20230821	☐ OUTPATIENT ☐ INPATIENT ☒ BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE New Student Indoctrination (NSI) Staff TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PERSON OR ORGANIZATION TO RECEIVE MY MEDICAL INFORMATION	b. ADDRESS (Street, City, State and ZIP Code)
BUMED(MAIL NOT ACCEPTED); DoDMERB	BUMED: fax (571-316-1527) or DoDSAFE; DoDMERB: email (dha.ncr.dod-merb.mbx.helpdesk@health.mil)
c. TELEPHONE (Include Area Code)	d. FAX (Include Area Code)

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION (X as applicable)
☐ PERSONAL USE ☒ CONTINUED MEDICAL CARE ☒ SCHOOL ☒ OTHER (Specify) NSI
☐ INSURANCE ☐ RETIREMENT/SEPARATION ☐ LEGAL

8. INFORMATION TO BE RELEASED
All NSI related outpatient and inpatient medical records, images, and reports (lab, rad, etc).

9. AUTHORIZATION START DATE (YYYYMMDD)	10. AUTHORIZATION EXPIRATION
20230608	☒ DATE (YYYYMMDD) 20230821 ☐ ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR 164.524.ss
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT (If applicable)	13. DATE (YYYYMMDD)
John R. Doe	Self	20221114

SECTION IV - FOR STAFF USE ONLY (To be completed only upon receipt of written revocation)

14. X IF APPLICABLE:	15. REVOCATION COMPLETED BY	16. DATE (YYYYMMDD)
☐ AUTHORIZATION REVOKED		

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:

DD FORM 2870, DEC 2003

Reset

This form should be placed into the athlete's medical file and should *not* be shared with schools or sports organizations. The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another History Form.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: John R. Doe Date of birth: 11-13-2004

Date of examination: 11-15-2022 Sport(s): New Student Indoctrination (NSI)

Sex assigned at birth (F, M, or intersex): M How do you identify your gender? (F, M, or other): Male

Have you had COVID-19? (check one): ☐ Y ☒ N

Have you been immunized for COVID-19? (check one): ☒ Y ☐ N If yes, have you had: ☐ One shot ☒ Two shots

List past and current medical conditions. Severe Acne

Have you ever had surgery? If yes, list all past surgical procedures. Yes. Broken Leg in June 2019

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

TWYNEO (For acne)

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Shellfish

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		×
2. Has a provider ever denied or restricted your participation in sports for any reason?	×	
3. Do you have any ongoing medical issues or recent illness?		×
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		×
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		×
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		×
7. Has a doctor ever told you that you have any heart problems?		×
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		×

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		×
10. Have you ever had a seizure?		×
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		×
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		×
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		×

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?	X	
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		X
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		X
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		X
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		X
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		X
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		X
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		X
22. Have you ever become ill while exercising in the heat?		X
23. Do you or does someone in your family have sickle cell trait or disease?		X
24. Have you ever had or do you have any problems with your eyes or vision?		X

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		X
26. Are you trying to or has anyone recommended that you gain or lose weight?		X
27. Are you on a special diet or do you avoid certain types of foods or food groups?	X	
28. Have you ever had an eating disorder?		X
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

2. Broken leg in 6/19. Restricted from football until 6/20.

14. Broken Femur 6/19.

27. I avoid shellfish due to allergies.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: John R. Doe

Signature of parent or guardian: NOT APPLICABLE

Date: 11/15/2022

This form should be placed into the athlete's medical file and should *not* be shared with schools or sports organizations. The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another examination.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

PHYSICAL EXAMINATION FORM

Name: John R. Doe Date of birth: 11-13-2004

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: 6'1 Weight: 197		
BP: 117 /77 (/) Pulse: 80 Vision: R 20/20 L 20/20 Corrected: ☐ Y ☐ N		
COVID-19 VACCINE		
Previously received COVID-19 vaccine: ☒ Y ☐ N Administered COVID-19 vaccine at this visit: ☐ Y ☒ N If yes: ☐ First dose ☐ Second dose		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)	×	
Eyes, ears, nose, and throat • Pupils equal • Hearing	×	
Lymph nodes	×	
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)	×	
Lungs	×	
Abdomen	×	
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis	×	
Neurological	×	
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck	×	
Back	×	
Shoulder and arm	×	
Elbow and forearm	×	
Wrist, hand, and fingers	×	
Hip and thigh	×	
Knee	×	
Leg and ankle	×	
Foot and toes	×	
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test	×	

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): Benjamin Franklin Pierce, MD Date: 11/15/2022

Address: 4077 Main Street, Suite 4, Friendship, ME 04547 Phone: 207-555-0005

Signature of health care professional: Benjamin Franklin "Hawkeye" Pierce (MD) DO, NP, or PA

The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: John R. Doe Date of birth: 11/13/2004

☒ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

☐ Medically eligible for certain sports

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations:

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): Benjamin Franklin Pierce, MD Date: 11/15/2022

Address: 4077 Main Street, Friendship, ME 04547 Phone: (207) 555-0005

Signature of health care professional: Benjamin Franklin "Hawkeye" Pierce M. D. MD DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: Shellfish

Medications: TWYNEO (For Acne)

Other information: Tylenol for headaches

Emergency contacts: Jane Doe, Mother, 123 Crabapple Lane, Friendship, ME 04547, Phone: (123) 456-7890

[redacted] [redacted]

Immunization Summary

[redacted]

Patient Information

Patient Name	MRN	Legal Sex	DOB
[redacted]	[redacted]	[redacted]	[redacted]

Current Immunizations

COVID-19 mRNA PF 30 mcg/0.3 mL Tris Sucrose (Pfizer) (GRAY CAP) (12 yrs and older)	4/6/2021 (16yr)	4/27/2021 (16yr)		
DTaP, 5 Pertussis Antigens	7/28/2004 (2mo)	9/29/2004 (4mo)	12/9/2004 (6mo)	9/22/2005 (15mo)
	8/25/2008 (4yr)			
HPV9	8/26/2016 (12yr)	8/14/2017 (13yr)		
Hep A, Ped/Adol, 2 Dose	2/24/2021 (16yr)			
Hep B, Adolescent or Pediatric	5/27/2004 (0day (s))	7/28/2004 (2mo)	12/9/2004 (6mo)	
Hepatitis A (Ped)	4/28/2022 (17yr)			
Hib (PRP-OMP)	7/28/2004 (2mo)	9/29/2004 (4mo)	12/9/2004 (6mo)	5/27/2005 (12mo)
INFLUENZA, INJECTABLE, QUADRIVALENT, PRESERVATIVE FREE	10/10/2014 (10yr)	1/24/2020 (15yr)	8/18/2020 (15yr)	YOU WILL NEED [redacted] FOR 2022/2023
IPV	7/28/2004 (2mo)	9/29/2004 (4mo)	12/9/2004 (6mo)	8/25/2008 (4yr)
Influenza, Seasonal, Injectable	9/21/2011 (7yr)	9/21/2012 (8yr)	11/12/2013 (9yr)	
Influenza, Split (Incl. Purified Surface Antigen)	11/14/2005 (17mo)	11/21/2006 (2yr)	9/25/2009 (5yr)	9/21/2011 (7yr)
	9/21/2012 (8yr)			
MMR	5/27/2005 (12mo)	8/25/2008 (4yr)		
Meningococcal B, OMV	2/24/2021 (16yr)			
Meningococcal MCV4O	2/24/2021 (16yr)			
Meningococcal MCV4P	8/26/2016 (12yr)			
Novel Influenza, H1N1-09	11/7/2009 (5yr)	12/3/2009 (5yr)		
Pneumococcal Conjugate PCV 7	5/27/2005 (12mo)	9/22/2005 (15mo)	1/9/2006 (19mo)	
Tdap	8/26/2016 (12yr)			
Varicella	5/27/2005 (12mo)	8/25/2008 (4yr)		

Vaccine Information

For more information about vaccines please visit the following website:
(Vietnamese) Xin truy cập trang mạng sau đây để có thêm, thông tin về thuốc chủng ngừa:
(Spanish) Por favor, visite el siguiente sitio de Internet para obtener más información sobre vacunas:

[redacted]

HEMOGLOBIN S SCREEN - Details

Result

***Collection and time columns refer to when the test was done.**

Exam	Result	Status	Collection*	Time*	Last Update
HEMOGLOBIN S SCREEN	Normal [2]	Final result	Nov 16, 2021	1116	Nov 17, 2021 1243

Component	Value	Ref Range & Units	Status
Sickle Cell Prep	Negative	Negative	Final

Test Name	Result	Flag	Reference Range	Lab
FASTING:NO				
FASTING: NO				
SICKLE CELL SCREEN				
SICKLE CELL SCREEN	NEGATIVE	NORMAL	NEGATIVE	01

Hemoglobin solubility testing alone is insufficient for detecting or confirming the presence of sickling hemoglobins in some situations. Additional testing may be required for diagnosis of hemoglobinopathies.

For additional information, please refer to http://education.questdiagnostics.com/faq/FAQ99v1 (This link is being provided for informational/ educational purposes only.)

- THESE ARE EXAMPLES OF WHAT SICKLE CELL TEST WILL BE ACCEPTED FOR NSI .