Monmouth University’s Athletic Department, Division of Sports Medicine, has adopted a policy following NCAA guidelines for Division I Student-Athletes, to require a sickle cell solubility screen as part of the pre-participation medical examination. This legislation is applicable to student-athletes who are beginning their initial year of eligibility at Monmouth University. This test must be administered prior to any athletics participation. The NCAA has provided fact sheets and an educational video available online at www.NCAA.org/health-safety.

**Ask your pediatrician:**
In most states infants are tested at birth for their sickle cell status. Your pediatrician may have the results of this lab test in your medical file. Please note we need the actual lab results not just a note from a doctor stating your sickle cell status.

**If you were born in NJ:**
If you were born in New Jersey you were tested at birth for sickle cell by the NJ Newborn Screening Laboratory. You can fill out the attached medical release authorization requesting the NJ Newborn Screening Laboratory to send your lab results to our office. The authorization can be faxed directly to the NJ Newborn Screening Laboratory.

**Get tested by your physician:**
The sickle cell lab screening can be completed with a laboratory blood screen with a prescription from your physician. The Hemoglobin (Hgb) Solubility or Sickle Cell Screen (CPT: 85660) is the test needed. Most insurance providers will cover the cost of this test. Please note we need the actual lab results not just a note from a doctor stating your sickle cell status.

**Schedule a test with Quest Diagnostics:**
You can schedule a test at a location convenient to you at Quest Diagnostics. To schedule the test go to https://sicklecelltesting.medivo.com/order/am. The cost for this will be $32.50 payable by the student athlete. Please note we need the actual lab results not just a note from a doctor stating your sickle cell status.

Please submit your lab results to:
Monmouth University Sports Medicine
Fax: (732) 263-5265
Email:MUSM@monmouth.edu

If you have any questions please call 732-571-4423 or email musm@monmouth.edu
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ___________________________________________________________
Address: ______________________________________________________________
City, State, Zip: __________________________________________________________
Date of Birth: __________________________________________________________
Mother’s Name:________________________________________________________

I hereby authorize and request Monmouth University Sports Medicine to obtain information from:

Facility Name: _____NJ Newborn Screening Laboratory________________________
Address: _____PO Box 371________________________________________________
City, State, Zip: _____Trenton, NJ 08625-0371______________________________
Telephone: _____(609) 530-8371_________________________________________
FAX: _____(609) 530-8373__________________________________________

FOR THE PURPOSE OF:
__X__ Continuation of care

SPECIFIED REPORTS:
__X__ Lab/Radiology reports for sickle cell screening

I understand that the information to be disclosed includes my identity, diagnosis and treatment including ALCOHOL, DRUGS, GENETIC TESTING, and BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, SEXUALLY TRANSMITTED AND INFECTIOUS DISEASES, AIDS and HIV information, as applicable.

I authorize the above person/organization and/or members of their staff to furnish the above information, including copies and faxed copies of the information directed in this authorization. I further agree to release the facility and its employees and agents from liability that may arise from the release of information herein requested.

I understand that this authorization is subject to revocation at any time, except the extent that the individual or entity that is to make the disclosure has already taken action in reliance upon it.

I also understand and agree that this authorization will terminate only upon the execution of my written statement indicating my intent to revoke this authorization and that without such written revocation; this authorization will expire in (6) months.

____________________________________________  ____________
Signature of Patient or Legal Representative  Date

____________________________________________  ____________
Witness  Date