**ORANGEBURG AREA **

**SICKLE CELL ANEMIA FOUNDATION, INC.**

##### **825 SUMMERS AVENUE**

##### **Post Office Box 892**

**Orangeburg, SC 29116-0892**

**telephone (803) 534-1716**

**Fax (803) 531-2422**

[**Orangeburgsickle@gmail.com**](mailto:Orangeburgsickle@gmail.com)

**CLIENT APPLICATION**

**\*Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Middle Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*State: \_\_\_\_\_\_\_\_ \*Zip Code: \_\_\_\_\_\_\_**

**\*Home#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Mobile#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Race: \_\_\_\_\_\_ \*Sex: \_\_\_\_\_**

**\*TYPE OF SICKLE CELL: (Please check what applies.)**

**-Hemoglobin SS \_\_\_\_\_\_\_\_\_ -Hemoglobin SC \_\_\_\_\_\_\_\_\_ -Hemoglobin SB+ (beta) thalassemia \_\_\_\_\_\_\_\_\_**

**-Hemoglobin SB 0 (Beta-zero) thalassemia \_\_\_\_\_\_\_ -Hemoglobin SD, Hemoglobin SE, Hemoglobin SO \_\_\_\_\_\_\_\_**

**\*PARENTS**

**\*Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*State\_\_\_\_\_\_\_\_\_\*Zip Code\_\_\_\_\_\_\_\_**

**\*Home#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Mobile#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*TYPE OF SICKLE CELL or TRAIT: (Please check what applies.)**

**-Hemoglobin SS \_\_\_\_\_\_\_\_\_ -Hemoglobin SC \_\_\_\_\_\_\_\_\_ -Hemoglobin SB+ (beta) thalassemia \_\_\_\_\_\_\_\_\_**

**-Hemoglobin SB 0 (Beta-zero) thalassemia \_\_\_\_\_\_\_ -Hemoglobin SD, Hemoglobin SE, Hemoglobin SO \_\_\_\_\_\_\_\_**

**-Trait \_\_\_\_\_\_\_\_\_ -None \_\_\_\_\_\_\_\_\_**

**\*Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*State\_\_\_\_\_\_\_\_\_\*Zip Code\_\_\_\_\_\_\_**

**\*Home#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Mobile#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*TYPE OF SICKLE CELL or TRAIT: (Please check what applies.)**

**-Hemoglobin SS \_\_\_\_\_\_\_\_\_ -Hemoglobin SC \_\_\_\_\_\_\_\_\_ -Hemoglobin SB+ (beta) thalassemia \_\_\_\_\_\_\_\_\_**

**-Hemoglobin SB 0 (Beta-zero) thalassemia \_\_\_\_\_\_\_ -Hemoglobin SD, Hemoglobin SE, Hemoglobin SO \_\_\_\_\_\_\_\_**

**-Trait \_\_\_\_\_\_\_\_\_ -None \_\_\_\_\_\_\_\_\_**

**\*MARITAL STATUS:**

**\*Marital Status: (Please check that applies.) Single \_\_\_\_\_\_ Married \_\_\_\_\_\_ Divorced \_\_\_\_\_ Widow \_\_\_\_\_\_**

**\*Name of Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Home#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Mobile#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*SERVICES REQUESTED: (Please check all that applies.)**

**-Case Management: \_\_\_\_\_\_ -Family Planning Counseling: \_\_\_\_\_\_ -Family Support Services: \_\_\_\_\_\_**

**-Genetic Counseling: \_\_\_\_\_\_ -Screening: \_\_\_\_\_\_**

**Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*EMPLOYER’S INFORMATION:**

**\*Employer/ Company’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*State: \_\_\_\_\_\_\_\_ \*Zip Code: \_\_\_\_\_\_\_\_**

**\*Telephone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*EDUCATION INFORMATION:**

**\*High School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*College: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Technical School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Vocational School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*PHYSICAN’S INFORMATION:**

**\*Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*State: \_\_\_\_\_\_\_\_ \*Zip Code: \_\_\_\_\_\_\_\_**

**\*Telephone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*State: \_\_\_\_\_\_\_\_ \*Zip Code: \_\_\_\_\_\_\_\_**

**\*Telephone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*\* Please have your physician FAX proof of Sickle Cell Disease to the Orangeburg Area Sickle Cell Anemia Foundation at 803-531-2422(fax).**

**\*\*\*Please SEND this application to: ORANGEBURG AREA SICKLE CELL ANEMIA FOUNDATION, INC.**

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