MD Department of Health
Office for Genetics and People With Special Health Care Needs
Sickle Cell Follow-Up Program
201 W. Preston Street, Room 423 A, Baltimore, MD 21201
Phone: (410)767-6737 Fax: (410)333-5047

Self-Referral Form

Name:_____DOB:_____
Parent(s) name:_____
(If under 18)
Address:_____
Telephone:_____ Is it ok to leave detailed message on voice mail? Yes ____
No____
Place of birth_____Hosptial_____
Previous address:_____
Provider(s)/specialists:
Maryland Providers (If applicable)
PCP:_____
Hematologist and/or center:_____

By self-referring to the Maryland Sickle Cell Follow up Program, you are giving (the program) permission to contact you and your provider to obtain information related to program requirements.
Please fax or mail us the form to the above address.