GENOTYPING REQUEST FORM: Haemophilia, VWD and other hereditary blood-coagulation disorders

Patient Sticker or Details	Referring consultant:
Surname:	
Forename:	**Hospital / address report to be sent to:**
DOB:	
Hosp. No:	
NHS No:	
Postcode:	
Sex: M / F	

Request reason: HA / HB / VWD / OTHER:		
Type of test: Unknown mutation / Carrier testing / Confirmation of mutation		
Is this an antenatal patient?	Yes / No	Gestation:
Comments:		

Request for genotyping check list

Patient/parent/guardian informed written consent:	Yes / No	
Has the patient provided consent for their sample to be stored?	Yes / No	
Has the patient provided consent for their result to be added to the database?	Yes / No	
Has the patient provided consent for their sample to be used for QA and/or sent to other laboratories?	Yes / No	
Family mutation known:	Yes / No	
Report photocopy enclosed:	Yes / No	
Name of index case:		
Family tree enclosed:	Yes / No	Family No. if known:
Date and Time of Sample:	Date:	Time:
Wet clotting results:		

*by signing this form, I confirm that written informed consent has been taken for the requested tests

Authorised by*:	Checked by:	Date:

Form approved at:	**Haemophilia Genetics Meeting, OHTC, 2016**