

NATIONAL HAEMOGLOBINOPATHY REFERENCE LABORATORY
REQUEST FORM: GENOTYPING OF HAEMOGLOBIN DISORDERS

PATIENT DETAILS (please fill in or attach addressograph)

Surname: First Name:

Gender: D.O.B: Ethnicity (essential): Sample date:

NHS No: Your reference number:

REASON FOR REFERRAL:

Is this patient related to another individual referred for testing / known to be a carrier or affected with a haemoglobinopathy?
 If so please provide: RELATIONSHIP DETAILS:
 RELATIVE NAME: RELATIVE Date of Birth: RELATIVE Genotype:

REQUESTER DETAILS

Referrer: Contact details (email or phone no):

Address for report: Address for invoice:

Is this an **ANTENATAL** patient/partner: YES / NO Gestation: Sample Type: BLOOD / DNA (please circle)

LABORATORY RESULTS: Please fill in or attach copy of own result form, and enclose a copy of HPLC results.

Hb g/l	RBC x 10 ¹² /l	MCV fl	MCH pg	Ferritin	HbA	HbA2	Hb F	Other
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

CLINICAL DETAILS / ANY OTHER RELEVANT INFORMATION:

HAS THIS PATIENT HAD: a blood transfusion within the past four months?
 a bone marrow transplant?

CONSENT for STORAGE and RESEARCH: Consent has been obtained for the DNA/RNA of this sample to be stored and used in research/development projects that have been granted ethical approval (please delete as appropriate): Yes / No

Signed Clinician Date

SAMPLE REQUIREMENTS: Preferably 4ml of blood in EDTA, labelled with patient's surname, first name, DOB, NHS number and the date of sampling, by first class post or courier. DNA is acceptable if red cell indices and referrer's HPLC (or equivalent) results are provided as requested above.

Further details and additional copies of this form can be found at: www.oxford-translational-molecular-diagnostics.org.uk/
 Please send samples to the following address: **Molecular Haematology, Level 4, John Radcliffe Hospital, Headington, Oxford, OX3 9DU**
 Sample reception: 01865 572769 Sec: 01865 572826 Email: oxford.molecularhaem@nhs.net

FAMILY ORIGIN INFORMATION QUESTIONNAIRE

A. MIXED (Please tick all boxes in sections B, C, D, E, F, G and H that apply to you)

Further information _____

Patient

B. WHITE

- English, Scottish, Welsh or Irish
- Other North European
- Any other white background _____

C. MEDITERRANEAN

- Greek or Greek Cypriot
- Turkish or Turkish Cypriot
- Italian, Maltese
- Any other Mediterranean background _____

D. ASIAN

- Indian or African-Indian
- Pakistani
- Bangladeshi
- Any other Asian background _____

E. SOUTH EAST ASIAN

- Chinese
- Japanese
- Thai, Vietnamese or Filipino
- Malaysian or Indonesian
- Any other SE Asian background _____

F. BLACK

- African
- Caribbean
- Any other black background _____

G. ARABIC

- Arab African
- Iranian
- Iraq
- Kurdish
- Any other Arabic background _____

H. DON'T KNOW