OXFORD Molecular Diagnostics Centre

Oxford University Hospitals NHS
NHS Foundation Trust

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

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 5ml 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 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 Fax: 01865 572775 Email: oxford.molecularhaem@nhs.net

FAMILY ORIGIN INFORMATION QUESTIONAIRE

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	☐