

For sending samples, see address below

Haemoglobinopathy screening queries: hbopathy.screening@nhs.net

Haemoglobinopathy service general advice: lab.support@nhs.net

**Oxford Genetics Laboratory Haemoglobinopathy Testing Service
 Genotyping of Haemoglobin Disorders Request Form**

Patient Details			
NHS No:		Sex:	
Surname:		Address:	
Forename:			
Date of Birth:		Postcode:	
Ethnicity: (See page 2)		Reference no:	

Requester Details			
Clinician:		Job Title:	
Email:		Phone No:	
Reporting address:		Invoice address if different:	

Family Details	
Please provide details (name, date of birth and genotype) of any related individuals (or reproductive partners) who are known to be a carrier or are affected with a haemoglobinopathy or who have been referred for testing.	

Clinical Information			
Reason for referral:			
Is the patient or partner antenatal?		Gestation:	
Sample type*:	DNA	Blood	Sample date:
Has this patient had:	A blood transfusion within the past 4 months?		<input type="checkbox"/>
	A bone marrow transplant?		<input type="checkbox"/>
Clinical details/other information:			

*SAMPLE REQUIREMENTS: **Preferably DNA** (ideally 50 µl and 50ng/µl, but lower quantities/concentrations may also produce successful results). Tubes should be labelled with patient's surname, first name, DOB and NHS number. **If a DNA sample is provided, the laboratory results specified below must be provided (ferritin is optional), either in the table or by attaching reports.** If these values are not available, 2ml blood in EDTA can be provided instead.

Laboratory Results – Please fill in or attach copy of own result form and enclose a copy of HPLC or CE results.								
Hb g/l	RBC x 10 ¹² /l	MCV fl	MCH pg	Ferritin	HbA	HbA ₂	Hb F	Other peaks

In submitting this sample the clinician confirms that informed consent has been obtained for: (a) storage and testing (current and future testing as this becomes available) (b) the use of this sample and the information generated from it to be shared with members of the donor's family and their health professionals (if appropriate) and (c) the information generated to be entered onto local and national confidential databases. If specific consent to any of the above is not given please provide details below. The patient should be advised that the sample may be used anonymously for quality assurance, training and research purposes.

Consent for research: Consent has been obtained for the DNA/RNA of this sample to be used in research/development projects that have been granted ethical approval:

Signed:			
Clinician:		Date:	

Further details and additional copies of this form can be found at: <https://www.ouh.nhs.uk/geneticslab>

Please send samples at room temperature by post or courier to:

Oxford Regional Genetics Laboratories, Churchill Hospital, Headington, Oxford, OX3 7LE

Version: 17.0

Email: oxford.molecularhaem@nhs.net

Please tick all boxes in in ALL sections that apply to the woman and the baby's biological father.

= Higher risk for alpha zero thalassaemia

Ethnicity	Woman	Biological Father
A. AFRICAN OR AFRICAN CARIBBEAN (BLACK)		
Caribbean Islands		
Africa (excluding North Africa)		
Any other African family origins		
B. SOUTH ASIAN (ASIAN)		
India or African-Indian		
Pakistan, Bangladesh, Sri Lanka		
C. SOUTH EAST ASIAN (ASIAN)		
China including Hong Kong, Taiwan	#	#
Singapore, Thailand, Indonesia	#	#
Malaysia, Vietnam, Philippines	#	#
Cambodia, Laos, Myanmar	#	#
Any other Asian family origins	#	#
D. OTHER NON-EUROPEAN (OTHER)		
North Africa, South America		
Middle East, Saudi Arabia, Iran		
Any other non-European family origins		
E. SOUTHERN AND OTHER EUROPEAN (WHITE)		
Sardinia	#	#
Greece, Turkey, Cyprus	#	#
Italy, Portugal, Spain		
Albania, Czech Republic		
Poland, Romania, Russia		
Any other Mediterranean country		
F. *UNITED KINGDOM (WHITE)		
England, Scotland, Northern Ireland, Wales		
G. *NORTHERN EUROPEAN (WHITE)		
Austria, Belgium, Switzerland, Scandinavia		
Eire, France, Germany, Netherlands		
Australia, North America, South Africa		
Any other European family origins		
*Hb Variant Screening Requested by (F) and/or (G)		
H. DON'T KNOW		
Adoption/unknown ancestry		
Donor egg/sperm (if pregnancy results from donor egg, order test for mother and offer biological father test immediately)		
Bone marrow transplant (if mother has had a bone marrow transplant, order test for mother and offer biological father test immediately)		
I. DECLINED TO ANSWER		

Information for Patients

Blood samples can be arranged via your GP or the phlebotomy clinic of your local hospital. This form must accompany the sample. Following receipt of the sample, laboratory staff are unable to provide information on samples and test results directly to patients or their relatives. Such enquiries should be directed to the referring clinical teams or the GP.