

REFERRAL FOR HAEMOGLOBINOPATHY SCREEN



Manchester University
NHS Foundation Trust

Laboratory Haematology

Trafford General Hospital
Moorside Road
Davyhulme
M41 5SL
Tel. No.: 0161 746 2111

Please send 1 x fresh EDTA patient sample (1ml min volume).

Patient Demographics	
First Name:	Surname:
D.O.B:	Male / Female:
NHS Number:	Hospital Number:
Was this requested as part of the Ante-natal Screening Programme Y/N	
Is the patient pregnant Y/ N Gestation Weeks = Days =	Is this baby's biological father Y / N Details of mother:
Your Lab. Number:	Date Specimen Collected:

Test Required: Haemoglobinopathy screen

Requestor **MUST** provide a copy of associated FBC results and chromatogram.

Parameter	Patient result	Your Reference Range
Hb (g/L)		
RBC (x10 ¹² /L)		
MCV (fl)		
MCH (mg)		
HCT (L/L)		
Ferritin (ug/L)		

FOQ data if applicable

Comments (clinical details/family history):

Sender Details	
Department:	
Address:	
Contact Number:	
Contact Name:	
Contact email:	

Signature:

Date Sent:

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Incorporating: Altrincham Hospital • Manchester Royal Eye Hospital • Manchester Royal Infirmary • North Manchester General Hospital • Royal Manchester Children's Hospital • Saint Mary's Hospital • Trafford General Hospital • University Dental Hospital of Manchester • Wythenshawe Hospital • Withington Community Hospital • Community Services

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