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:** ……