Paroxysmal Nocturnal Haemoglobinuria
Additional Information Form
HAEMATOLOGY DEPARTMENT

CPL, St. James's Hospital, Dublin 8.
Tel.: (01) 4162048

FOR LABORATORY USE ONLY
PLEASE AFFIX SPECIMEN NUMBER BARCODE LABEL HERE

Patient Details (Complete Fully OR Attach an Addressograph Label inside the dotted line below):

Surname

First Name **Male** **Female**

Date of Birth / / **Hospital number/MRN**

Patient's Address: _____

IMPORTANT Please provide clinical details below

LDH (IU/L):

Reticulocyte count:

Aplastic Anaemia:
Suspected Known N/A

eGFR (mL/min):

Haemoglobinuria:
Yes No

Myelodysplastic Syndrome:
Suspected Known N/A

Creatinine (µmol/L):

Hb (g/dL)

Previous blood transfusion:
Yes No
Date:

Urea (mmol/L):

Platelets ($x10^9$/L):

Bilirubin (µmol/L):

WCC ($x10^9$/L):

Neutrophils ($x10^9$/L):

Blood film abnormalities:

Previous Thrombosis:

Yes No

Site:

Date:

Sample Requirements: EDTA peripheral blood – taken <48hrs before testing, at least 3mls

Please provide details below as significant results will be phoned

Requesting clinician **Telephone**

Hospital **E-mail**

Signature