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| **Haemoglobinoapthy Laboratory Request Form** clear James logo (2)**HAEMATOLOGY LABORATORY****LabMed Directorate, St. James’s Hospital, Dublin 8.** **Tel.: 01 4162048/4162394 Fax: 01 4162920 www.stjames.ie**  | **FOR SJH LABORATORY USE ONLY. PLEASE AFFIX SPECIMEN NUMBER BARCODE LABEL HERE** |
| **All sections of this form MUST be completed by the requesting medical team. Samples may not be analysed unless a FULLY COMPLETED AND CLEARLY WRITTEN request form accompanies the samples.** |
| **PATIENT DETAILS:** **Surname** **First Name Male Female** **Date of Birth / / MRN** **Patient’s Address: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **REFERRER'S DETAILS:** **Referring Hospital:****Ward/Secondary Location:** **Referring Clinician and Contact Details:** |
| **CLINICAL DETAILS/ REASON FOR REFERRAL :** Patient’s Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pregnant: **Yes** **No** **Unknown**Has the patient been **transfused** in the past 4 months?  **Yes** **No** **Unknown**Other details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **PLEASE COMPLETE FOR PRE-CONCEPTION/ANTENATAL SCREENING:** Number of Weeks Gestation: \_\_\_\_\_\_\_\_\_\_\_\_\_ Biological Father’s Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **TEST REQUESTED:**Haemoglobinopathy Screen G6PD Screen **External Laboratory Test Request Number:**  |
| **DATE AND TIME OF SAMPLE COLLECTION:** |
| **HAEMATOLOGY INDICES:**

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| Haemoglobin |  | MCV |  | RDW |  |
| Red Cell Count |  | MCH |  | Reticulocyte Count |  |
| White Cell Count |  | MCHC |  | Ferritin |  |

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| **DATE AND TIME RECEIVED IN SJH LAB:**  |