

Haemoglobinopathy Laboratory Request Form

HAEMATOLOGY LABORATORY

LabMed Directorate, St. James's Hospital, Dublin 8.

Tel.: 01-4162394 www.stjames.ie



FOR SJH LABORATORY USE ONLY. PLEASE AFFIX SPECIMEN NUMBER BARCODE LABEL HERE

Ensure form is **FULLY COMPLETED AND CLEARLY WRITTEN** by the requesting medical team.
(1 **EDTA** sample and 1 **SERUM** sample required for Haemoglobinopathy Screen)
(Refer to User Guide)

ESSENTIAL DETAILS (Please provide): (Ensure Forename & Surname clearly identified if using label)

Surname

First Name Male Female

Date of Birth / / MRN

Patient's Address: _____

DATE AND TIME OF SAMPLE COLLECTION:

EXTERNAL LAB TEST REQUEST NUMBER:

TEST REQUESTED:

(Do Not Refrigerate)

Haemoglobinopathy Screen G6PD Screen Plasma Viscosity
Altered Affinity Haemoglobin screen

REFERRER'S DETAILS: (Please no Abbreviations)

Referring Hospital: (FULL NAME)

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

Is patient Diabetic? Yes No

Other details: _____

PLEASE COMPLETE FOR PRE-CONCEPTION/ANTENATAL SCREENING:

Number of Weeks Gestation: _____ Biological Father's Ethnicity: _____

DATE AND TIME RECEIVED IN SJH LAB: