

For sending samples, see address below

Haemoglobinopathy screening queries: [hbopathy.screening@nhs.net](mailto:hbopathy.screening@nhs.net)

Haemoglobinopathy service general advice: [lab.support@nhs.net](mailto:lab.support@nhs.net)

## Oxford Genetic Laboratory Haemoglobinopathy Testing Service

### Prenatal Diagnosis of Haemoglobin Disorders Request Form

Mother's Details		Partner's Details	
NHS No:		NHS No:	
Surname:		Surname:	
Forename:		Forename:	
Date of Birth:		Date of Birth:	
GP Name:		GP Address:	
Antenatal booking hospital:			

Requester Details			
Clinician:		Job Title:	
Email:		Phone No:	
Reporting address:		Invoice address if different:	

Sample Details					
Indication of risk:		Date/time of fetal sample:			
Mother's genotype:		Father's genotype:			
Gestation at sampling:		EDD:			
Cytogenetics lab used for cleaning/culturing:					
Types of samples sent: (DNA is preferred, see also requirements for parental samples below)	Maternal DNA	Maternal blood	Paternal DNA	Paternal blood	
	CVS DNA	CVS	Fetal blood DNA	Fetal blood	
	Amniotic fluid DNA		Amniotic fluid		
	Cultured CVS DNA	Cultured CVS cells	Cultured amnio DNA	Cultured amnio cells	

Sample Requirements (see also specimen requirements)	
Fetal samples:	Fetal DNA/cleaned up CVS in transport medium/Amniotic Fluid (>10 mls)
Parental samples:	Extracted DNA <b>(if sending DNA please also send parental full blood count &amp; HPLC/CE results)</b> or fresh EDTA blood samples (ideally 2x2 mls).

Please telephone or email the laboratory (using the contact details below) to give prior notice before sending any fetal samples.

<p><b>In submitting this sample the clinician confirms that informed consent has been obtained for</b> (a) storage and testing (current and future testing as this becomes available) (b) the use of the parental samples and the information generated from it to be shared with members of the donor's family and their health professionals (if appropriate) and (c) the information generated to be entered onto local and national confidential databases. If specific consent to any of the above is not given please provide details below. Patients should be advised that their samples may be used anonymously for quality assurance, training and research purposes.</p>	
<p><b>Consent for research:</b> Consent has been obtained for the DNA/RNA of this sample to be used in research/development projects that have been granted ethical approval:</p>	
<p><b>Signed:</b></p>	<p><b>Date:</b></p>

Clinical Leads: Dr. Noemi Roy

Principal Clinical Scientist: Dr. Melanie Proven.

**Address to send PND referrals:**

**NHSE samples:** West Midlands Regional Genomics Laboratory, Birmingham Women's Hospital, Birmingham, B15 2TG

**Other samples:** Oxford Regional Genetics Laboratories, Churchill Hospital, Oxford, OX3 7LE

Please tick all boxes in in ALL sections that apply to the woman and the baby's biological father.

# = Higher risk for alpha zero thalassaemia

Ethnicity	Woman	Biological Father
<b>A. AFRICAN OR AFRICAN CARIBBEAN (BLACK)</b>		
Caribbean Islands		
Africa (excluding North Africa)		
Any other African family origins		
<b>B. SOUTH ASIAN (ASIAN)</b>		
India or African-Indian		
Pakistan, Bangladesh, Sri Lanka		
<b>C. SOUTH EAST ASIAN (ASIAN)</b>		
China including Hong Kong, Taiwan	#	#
Singapore, Thailand, Indonesia	#	#
Malaysia, Vietnam, Philippines	#	#
Cambodia, Laos, Myanmar	#	#
Any other Asian family origins	#	#
<b>D. OTHER NON-EUROPEAN (OTHER)</b>		
North Africa, South America		
Middle East, Saudi Arabia, Iran		
Any other non-European family origins		
<b>E. SOUTHERN AND OTHER EUROPEAN (WHITE)</b>		
Sardinia	#	#
Greece, Turkey, Cyprus	#	#
Italy, Portugal, Spain		
Albania, Czech Republic		
Poland, Romania, Russia		
Any other Mediterranean country		
<b>F. *UNITED KINGDOM (WHITE)</b>		
England, Scotland, Northern Ireland, Wales		
<b>G. *NORTHERN EUROPEAN (WHITE)</b>		
Austria, Belgium, Switzerland, Scandinavia		
Eire, France, Germany, Netherlands		
Australia, North America, South Africa		
Any other European family origins		
*Hb Variant Screening Requested by (F) and/or (G)		
<b>H. DON'T KNOW</b>		
Adoption/unknown ancestry		
Donor egg/sperm (if pregnancy results from donor egg, order test for mother and offer biological father test immediately)		
Bone marrow transplant (if mother has had a bone marrow transplant, order test for mother and offer biological father test immediately)		
<b>I. DECLINED TO ANSWER</b>		