# Thalassaemia Screen Request

## Patient Details

<table>
<thead>
<tr>
<th>Surname / Last Name</th>
<th>Given Name(s) / First Name(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
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**Controlled Copy**

1 of 1

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**Tsan Yuk Hospital**

Prenatal Diagnostic Lab

Address: 30 Hospital Road, Hong Kong
Tel: 25892218
Fax: 25172373

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**THALASSAEMIA SCREEN REQUEST**

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## Referring Doctor Details

<table>
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<th>Name (Print / Staff Name Chop)</th>
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### Clinical Details

**Wife:**
- □ α thal carrier
- □ β thal carrier
- □ αβ thal carrier
- □ low MCV
- □ Others: ________________________________

**Husband:**
- □ α thal carrier
- □ β thal carrier
- □ αβ thal carrier
- □ low MCV
- □ Others: ________________________________

**For:**
- □ CVS
- □ Amniocentesis

**Previous baby/fetus with:**
- □ α thal major
- □ β thal major

(Year of diagnosis: ___________, Lab no.: ___________)

**Previous prenatal diagnosis:**

Year: ___________, Lab no.: ___________

**For pregnant patients:**

L.M.P. (DD/MM/YYYY) ___________, E.D.C. by scan (DD/MM/YYYY) ___________, Gestation by scan wk ___________, d ___________

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### Haematological Investigation

<table>
<thead>
<tr>
<th>Mother</th>
<th>Father</th>
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</table>

**Name**

**Nativity (籍貫) 如: 中山**

**Hb (g/dl)**

**MCV (fl)**

**HbA2 (%)**

**HbH Inclusions**

**HbF (%)**

**Others**

**Ferritin**

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### Comments:

**Referring doctor’s signature:**

**Request date (DD/MM/YYYY):** ___________, ___________, ___________

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**Laboratory Use Only**