

## Prenatal Diagnostic Laboratory, Tsan Yuk Hospital Address: 30 Hospital Road, Hong Kong Tel: 25892218 Fax: 25172373



## THALASSAEMIA SCREEN REQUEST

PATIENT DETAILS Clinic	: / Hospital No.:		REFERRING DOCTOR DETAILS
Surname / Last Name	offix gum label or complete in full)		Name (Print / Staff Name Chop)
Given Name(s) / First Name(s)			Tel: Fax:
中文姓名	(ID / Document ID	Age	
Gender Da	ite of Birth (DD/MM/YYYY) PDC N	o.:	Referring Hospital Ward / Clinic
□Female □Male			
CLINICAL DETAILS			
Wife: $\Box \alpha$ thal carrier $\Box \beta$ thal carrier $\Box \alpha \beta$ thal carrier $\Box \log$ MCV $\Box$ Others:			
Husband: $\square \alpha$ thal carri	rier $\Box \beta$ thal carrier $\Box \alpha \beta$ thal carrier $\Box$ low MCV $\Box$ Others:		
For:   CVS   Amniocentesis			
Previous baby/fetus with $\Box \alpha$ thal major $\Box \beta$ thal major (Year of diagnosis:, Lab no.:)			
□Previous prenatal diagnosis Year:, Lab no.:			
For pregnant patients:		by scan (DD/MM	/YYYY) Gestation by scan wk d
HAEMATOLOGICAL INVES	TIGATION Mother		Father
Name			
Nativity (籍貫) 如: 中山			
Hb (g/dl)			
MCV (fl)			
HbA2 (%)			
HbH Inclusions			
HbF (%)			
Others			
Ferritin			
COMMENTS:			
Referring doctor's signature:  Request date (DD/MM/YYYY):			
LABORATORY USE ONLY			

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