ANTENATAL HAEMOGLOBINOPATHY SCREENING ALERT
REFERRAL FORM

Does the mother want a referral to clinical genetics? ** Choose an item.**
(Please note that even if low risk of haemoglobin disorder in pregnancy, parents may have questions about their own carrier status)

Name of person completing form…… Base……
Contact phone number:…… Fax……
Date form sent: ……...

PLEASE COMPLETE FORM EVEN IF COUPLE HAVE DECLINED REFERRAL

Maternal Details

Surname**	**First Name****
DOB**	**NHS number****
LMP (or EDD by scan) **	**Contact Telephone number(s) ****
Address including postcode**	**GP (including practice name) ****
	Community Midwife name and base (in full) **
Trust Booking** Choose an item.	**Interpreter Required (state language required) **** Choose an item.
Haemoglobinopathy Result** Choose an item.	**Family Origin**** Choose an item.
Has result been given to mother? Choose an item.	**Date Tested**

Paternal (Father of Baby) Details (Please mark NK if not known)

Surname**	**First Name****
DOB**	**NHS number****
Address including postcode (if different from mother)	**Contact Telephone number(s)**
	GP (including practice name)
Father of baby tested ** Choose an item.	**Family Origin** Choose an item.
Date tested (if applicable)	**Haemoglobinopathy Result** Choose an item.
Is father of baby aware of his result? Choose an item.	**Consent to share result with mother? **** Choose an item.

Please send completed form securely to NBTHaemoglobinopathyService@nbt.nhs.uk

**Fields marked are essential. We will not accept alert forms where these fields are not completed