viapath

(Request Card Label Here)
Viapath Admin Only

Special Haematology
Red Cell Referral Form

Hospital Number: ______
Surname: ______
First Name: ______
Gender: ______
Date of Birth: ______
NHS Number: ______

Referring Consultant: ______
Referring Hospital: ______
Address for Reporting: ______
Post Code: ______

Clinical Details/ Suspected Diagnosis:
(If diagnosis known, please specify)

Family History:

(Affix Originating Hospital Patient Label Here)

Infection Risk? YES / NO
If YES, please specify: ______

☐ NHS ☐ Private ☐ Research

Specimen Type:
☐ Peripheral Blood
☐ Blood Spot
☐ DNA
☐ Other
Specify: ......

Ethnicity: ______

Other Test Results:

Full Blood Count Results:
(Please provide a copy of the results if available)

WBC: ______
Hb: ______
RBC: ______
MCV: ______
MCH: ______
RDW: ______
Reticulocytes: ______
Ferritin: ______

Sample Collection:
(REQUIRED - Requests without this filled in will not be processed)

Date: ______
Time: ______
By: ______

DD/MM/YYYY INITIALS
VIAPATH ADMIN ONLY

Routine Testing:

☐ **Haemoglobinopathy Screen**
(High Performance Liquid Chromatography)
(Minimum 1mL EDTA required)

Non-Molecular Confirmatory Testing:

☐ **Mass Spectrometry Confirmation of Haemoglobins**
(S / C / E / F / OArab / DPunjab / Lepore / GPhiladelphia / Stanleyville II)
- Please note, only the above haemoglobin variants are detectable through our **Mass Spectrometry Assay**
(Minimum 1mL EDTA required)

Specialist Testing:

☐ **G6PD (Quantitative Assay)**
(FBC & Reticulocyte count + % must be provided)
(Minimum 1mL EDTA required)

☐ **P50 (High Affinity Haemoglobin)**
(Contact Laboratory Prior to Bleeding Patient)
(Minimum 1mL EDTA required)

☐ **HbH (Staining)**
(Sample must be less than 24 hours old)
(Minimum 1mL EDTA required)

☐ **Heinz Bodies (Staining)**
(Contact Laboratory Prior to Bleeding Patient)
(Minimum 1mL EDTA required)

Other Testing:

Please Specify: ______

Molecular Confirmatory Testing:

☐ **Alpha Thalassaemia Investigation**
(Identification of the seven common deletions)
(Minimum 1mL EDTA required)

☐ **Alpha Globin Gene Sequencing**
(Sequencing of point mutations and small deletions/insertions on the alpha globin gene)
(Minimum 1mL EDTA required)

☐ **Beta Globin Gene Sequencing**
(Sequencing of point mutations and small deletions/insertions on the beta globin gene)
(Minimum 1mL EDTA required)

☐ **Large Beta Globin Gene Deletion Investigations**
(MLPA to detect large beta globin gene deletions/duplications)
(Minimum 1mL EDTA required)

☐ **Other Molecular Testing**
(Specific testing not listed above)

Please Specify: ______

Confirmatory Testing Declaration:

☐ I **DO** want further testing to be performed in the case of abnormal screening results or negative Mass Spectrometry results.

☐ I **DO NOT** want further testing to be performed in the case of abnormal screening results or negative Mass Spectrometry results.

Full Name: ______
Signature: ______
Telephone: ______
E Mail Address: ______

Please send all samples to:
Special Haematology
c/o Central Specimen Reception,
Blood Science Laboratory,
4th Floor, Southwark Wing,
***Guy's Hospital**, Great Maze Pond,*
London, SE1 9RT

For Any Queries or Advice:

Red Cell Telephone: **020 718 83421**
White Cell Telephone: **020 718 82709**
Website: www.viapath.co.uk