Guidance Notes: FRM 4A

Haemoglobinopathy patient genotyping - Test request guidance information

USE BLOCK CAPITALS & DO NOT USE INITIALS OR ABBREVIATIONS

Ensure samples tubes have **three points of ID,** as recorded on the test request.
Refer to the reverse of the form for more detailed information.

Samples MUST have handwritten labels unless the use of demand printed labels has been agreed with NHSBT. All samples must be signed and dated.

Results may be delayed, or samples may not be tested if the form and sample labels are not completed correctly.

Enter **PATIENT DETAILS**
THREE points of I.D.
ID 1 = Forename & surname
ID2 = DoB
ID3 = NHS/CHI/HCS No

NHS No. is essential

CONSENT must be discussed with the patient and ticked

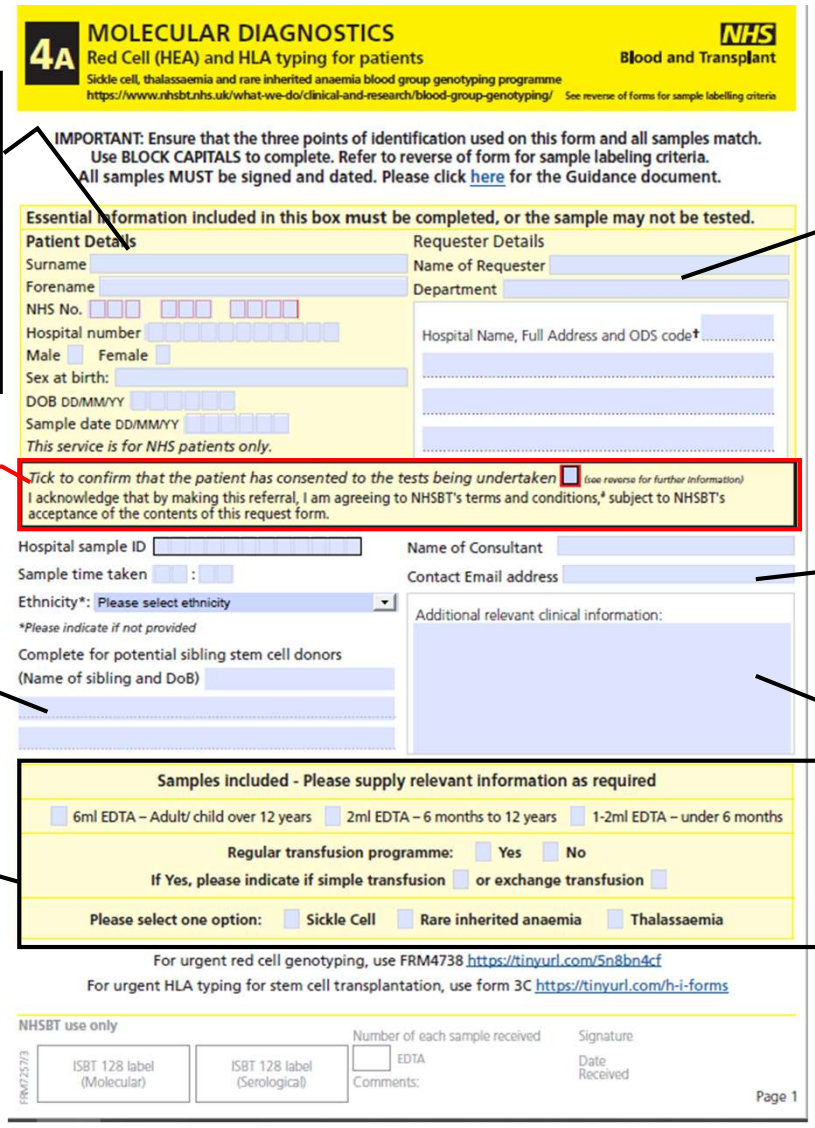
Complete potential related donor

Tick only **ONE BOX** for each

PRINT Contact details **FULL HOSPITAL NAME & ADDRESS**
Enter **ODS CODE** if known

Accredited secure domain or nhs.net

Enter **RELEVANT** clinical details



4A MOLECULAR DIAGNOSTICS
Red Cell (HEA) and HLA typing for patients
Sickle cell, thalassaemia and rare inherited anaemia blood group genotyping programme
https://www.nhsbt.nhs.uk/what-we-do/clinical-and-research/blood-group-genotyping/ See reverse of forms for sample labelling criteria

NHS Blood and Transplant

IMPORTANT: Ensure that the three points of identification used on this form and all samples match.
Use BLOCK CAPITALS to complete. Refer to reverse of form for sample labeling criteria.
All samples MUST be signed and dated. Please click here for the Guidance document.

Essential information included in this box must be completed, or the sample may not be tested.

Patient Details
Surname
Forename
NHS No.
Hospital number
Male Female
Sex at birth:
DOB DD/MM/YY
Sample date DD/MM/YY
This service is for NHS patients only.

Requester Details
Name of Requester
Department
Hospital Name, Full Address and ODS code†

Tick to confirm that the patient has consented to the tests being undertaken (see reverse for further information)
I acknowledge that by making this referral, I am agreeing to NHSBT's terms and conditions,* subject to NHSBT's acceptance of the contents of this request form.

Hospital sample ID
Sample time taken :
Ethnicity*: Please select ethnicity
*Please indicate if not provided
Complete for potential sibling stem cell donors
(Name of sibling and DoB)

Name of Consultant
Contact Email address
Additional relevant clinical information:

Samples included - Please supply relevant information as required
6ml EDTA – Adult/ child over 12 years 2ml EDTA – 6 months to 12 years 1-2ml EDTA – under 6 months
Regular transfusion programme: Yes No
If Yes, please indicate if simple transfusion or exchange transfusion
Please select one option: Sickle Cell Rare inherited anaemia Thalassaemia

For urgent red cell genotyping, use FRM4738 https://tinyurl.com/5n8bn4cf
For urgent HLA typing for stem cell transplantation, use form 3C https://tinyurl.com/h-i-forms

NHSBT use only
ISBT 128 label (Molecular)
ISBT 128 label (Serological)
Number of each sample received EDTA
Comments:
Signature
Date Received
FRM25373
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This information document, test request forms and more information about this programme can be found at https://www.nhsbt.nhs.uk/ibgrl/services/molecular-diagnostics/nhs-england-programme-for-haemoglobinopathy-blood-group-genotyping/

Please note: hospital derived request forms must include all the information above with the exception of 'potential sibling stem cell donors'.

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