

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

Referring Hospital: _____
Address for Reporting: _____
Post Code: _____
Referring Laboratory contact details
Full Name: _____
Telephone: _____
E mail Address: _____

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

(Affix Originating Hospital
Patient Label Here)

Infection Risk? YES /
NQs, please specify: _____

Antenatal? Yes / No

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: _____

DD/MM/YYYY INITIALS

SYNNOVIS ADMIN ONLY

Routine Screening Testing:

- ☐ **Haemoglobinopathy Screen**
(High Performance Liquid Chromatography)

Haemoglobinopathy 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 by this assay
(Minimum 1mL EDTA required)
- ☐ **Isoelectric Focusing**
(Minimum 1mL EDTA required)
- ☐ **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: _____

Enzyme Assays:

(FBC & Reticulocyte count + % must be provided)

- ☐ **G6PD Screen (Qualitative Assay)**
(Minimum 1mL EDTA required)
Please note: Dependent on FBC results provided and sample age, a G6PD assay may be performed if a G6PD screen is unsuitable. Equivocal/deficient screens will be followed up with a quantitative G6PD assay.
- ☐ **G6PD (Quantitative Assay)**
(Minimum 1mL EDTA required)
- ☐ **Pyruvate Kinase**
(Minimum 1mL EDTA required)
- ☐ **Other Enzyme Testing**
(Specific testing not listed above)
Please Specify: _____

Other Specialised Testing:

- ☐ **P50 (High Affinity Haemoglobin)**
(Contact Laboratory Prior to Bleeding Patient)
(Minimum 1mL EDTA required)
- ☐ **EMA dye binding (hereditary spherocytosis screening)**
(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)

Confirmatory Testing Declaration:

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

For Any Queries or Advice:

Telephone: 020 459 10045 /
020 459 10023

E mail: redcelllab@synnovis.co.uk

Website: www.synnovis.co.uk

Please send all samples to:

Specialist Red Cell Centre

Synnovis Hub Site, Floor 2
Friars Bridge Court
41-43 Blackfriars Road
SE1 8NZ