Specialist Red Cell Centre

Referral Form

(Request Card Label Here)

Synnovis Admin Only

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)

Antenatal? Yes / No

(Affix Originating Hospital Patient Label Here)

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

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