synnovis
A SYNLAB pathology partnership

Special Haematology

Red Cell Referral Form

(Request Card Label Here)

Synnovis Admin Only

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

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
SYNNOVIS ADMIN ONLY

Specimen Type:

- ☐ Peripheral Blood
- ☐ Blood Spot
- ☐ DNA
- ☐ Other
  Specify: .....

Ethnicity:

Other Test Results:

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 by this **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)

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: _____

Other Testing:

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:

For Any Queries or Advice:

Red Cell Telephone: **020 718 83421**
White Cell Telephone**: 020 718 82709**
Website: www.synlab.co.uk/synnovis

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