AWMGS
All Wales Medical Genomics Service

REFERRAL FORM FOR SICKLE CELL AND THALASSAEMIA COUNSELLING

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PATIENT NAME:		DATE OF REFERRAL:	
PATIENT ADDRESS: POST CODE:		NHS NUMBER: LAB NUMBER:	
PATIENT TELEPHONE NUMBER:		ETHNIC ORIGIN:	
DATE OF BIRTH:			
REFERRER NAME (TITLE, SURNAME), ADDRESS, TELEPHONE NUMBER:			
GP NAME, ADDRESS, TELEPHONE NUMBER:			
REASON FOR REFERRAL:			
IS THE PATIENT AWARE OF THE REFERRAL	**YES** ☐	**NO** ☐	
DOES THE PATIENT REQUIRE AN INTERPRETER	**YES** ☐	**NO** ☐	
IF YES, WHICH LANGUAGE:			
NAME OF AFFECTED FAMILY MEMBER (where applicable): RELATATIONSHIP TO PATIENT:			
PLEASE ATTACH PATIENT RESULTS			