

REFERRAL FORM FOR SICKLE CELL AND THALASSAEMIA COUNSELLING

Karenza Evans (Genetic Counsellor), Sickle Cell and Thalassaemia Services,
Wales Genomic Health Centre: 02921 834 000

Se.genetics@wales.nhs.uk

PATIENT NAME:		DATE OF REFERRAL:	
PATIENT ADDRESS:		NHS NUMBER:	
POST CODE:		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 <input type="checkbox"/>	NO <input type="checkbox"/>
DOES THE PATIENT REQUIRE AN INTERPRETER		YES <input type="checkbox"/>	NO <input type="checkbox"/>
IF YES, WHICH LANGUAGE:			
NAME OF AFFECTED FAMILY MEMBER (where applicable):			
RELATATIONSHIP TO PATIENT:			
PLEASE ATTACH PATIENT RESULTS			