ANTENATAL THALASSAEMIA/HAEMOGLOBINOPATHY SCREENING

Family of Origin Questionnaire

SA PATHOLOGY

Your family's genetic makeup may influence your child's future health. Having your family's ancestry is important to us when interpreting the findings of these tests. Please refer to the country key when answering the questions below.

Woman's details	Partner's details
Given name:	Given name:
Family name:	Family name:
Date of birth:	Date of birth:
Address:	Address:
Medicare number:	Medicare number:

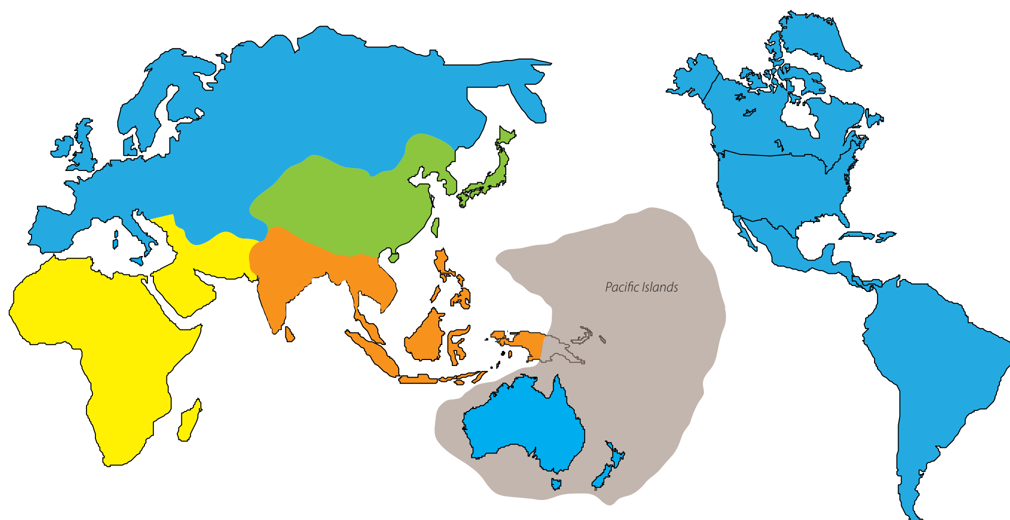
Is there a known family history of thalassaemia and/or haemoglobin variant?
(e.g. sickle cell haemoglobin, haemoglobin E or C)

Woman ☐ Yes ☐ No ☐ Not sure   Partner ☐ Yes ☐ No ☐ Not sure

What are your or your family's origins?

Please tick *all* boxes that apply.

	Region of family/ancestral origin	Woman	Partner
	Caucasian - United Kingdom Europe/North America/Australia	☐	☐
	Aboriginal - Torres Strait islanders/Pacific Islands	☐	☐
	South Asian - including the Indian subcontinent	☐	☐
	Oriental - Japan, Taiwan, Korea and China	☐	☐
	Afro-Carribbean - Africa/Middle East/other African origins	☐	☐



Clinicians complete overleaf →

To be completed by Clinician

Referral to Haematology Genetic MDT

Thalassaemia/Haemoglobinopathy Pre-conceptional/Antenatal testing

This referral will not result in a clinic appointment. The MDT will review information for the couple and issue a summary letter.

Please complete both sides of this form and attach all relevant test results for both partners.

Screening test checklist	Female partner	Male partner
CBE		
Iron Studies		
Hb variant analysis		

If tests have been performed in SA Pathology copies need not be attached.

Additional relevant information or attach letter.

Copy of report to other clinicians:

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Office Use ONLY	
EDC:	Consanguinous Couple ☐ Yes ☐ No
Gestation:	If yes: Relationship ________________
UR number:	Current Pregnancy: IVF ☐ Yes ☐ No
Location:	If yes: Donor Egg ☐ Yes ☐ No
(Hosp. Shared Services, Dr's rooms)	Donor Sperm ☐ Yes ☐ No