Molecular Genetic Request for
Hereditary Haemochromatosis (HH)

Please complete form and return with **3 mls EDTA blood** to ***Clinical Biochemistry at CUH.***
(Please note: minimum age for carrier testing is 16 years in accordance with international guidelines.)

Patient Details:

M.R.N.: ______________________________

WARD: ______________________________

Name: ______________________________

Address: ______________________________

____

D.O.B.: ______________________________

Requestor Details:

Clinician: ______________________________

Address: ______________________________

____

____

____

Tel No: ______________________________

Gender: Male ☐ Female ☐ **Ethnic Origin:**__________________

REASON FOR REFERRAL: **Diagnostic** ☐ **Carrier status** ☐

Has your patient had *Venesection*? **Yes** ☐ **No** ☐

Please tick boxes and provide levels

↑ Fasting Transferrin Sat.	☐	_____%	**Diabetes Mellitus**	☐
↑ Serum Ferritin	☐	______ng/ml	**Cardiomyopathy**	☐
Abnormal LFTs	☐		**Arthritis**	☐

FAMILY HISTORY:

Is there a relative with confirmed HH? Yes ☐ No ☐ Relationship ____________________

Was diagnosis based on genetic testing? Yes ☐ No ☐ Genotype ______________________

Name of Relative ________________________________; Date of Birth __________________

Patient Consent: My doctor has discussed genetic testing for haemochromatosis with me and I fully understand the implications of this test. (Pl*ease tick relevant box)*

I consent to have a genetic test for haemochromatosis. Yes ☐ No ☐

I consent to use of my sample for training and quality assurance purposes. Yes ☐ No ☐

I consent to use of my sample for ethically approved HH related research. Yes ☐ No ☐

Patient's signature ______________________ **Date & Time** ___________________

Doctor's signature ______________________ **Date & Time** ___________________

Please note all samples are stored indefinitely, unless we receive a request in writing for the sample to be discarded

Advise photocopy and retain copy for patient record