Honesty Equality Accountability Respect Teamwork

Putting **patients** at the **HEART** of everything we do

NHS
London North West University Healthcare
NHS Trust

REFERRAL FORM

Haemoglobinopathy Screening Laboratory, The Doctors Laboratory, Central Middlesex Hospital, Acton Lane, London NW10 7NS Tel: 0208 453 2671 Email: LNWH-tr.CMHscreening@nhs.net

SURNAME	
FORENAME	
DOB	
SEX	
ETHNIC ORIGIN	
NHS NUMBER	
YOUR REF NO.	

Date of sample
____/____/____

CLINICAL DETAILS

Please ensure your reference number is completed

PATIENT ADDRESS

INVESTIGATIONS ALREADY CARRIED OUT
(with findings) (use attachments if possible)

FBC: Attach photocopy if possible or fill in below

RBCs		FER	
HB		Sickle	
MCV			
MCH			

YOUR CONTACT NAME	
TELEPHONE NO:	
EMAIL (NHS)	

For CMH use only

PLEASE ENSURE THAT ALL INVOICING DETAILS ARE CORRECT & COMPLETED WITH EACH REQUEST

PURCHASE ORDER NO

INVOICE DETAILS

EMAIL for REPORT @nhs.net

ADDRESS for REPORT