HAEMOGLOBINOPATHIES

DISEASE

Note: complete this form only if this diagnosis was the indication for the HCT/CT or if it was specifically requested. Consult the manual for further information.

Date of diagnosis/date of first event: _ _ _ _ / _ _ / _ _ *(YYYY/MM/DD)*

Classification:

☐ Thalassaemia
- ☐ Beta 0
- ☐ Beta+
- ☐ Beta E
- ☐ Beta S (sickle cell + thalassaemia): Percentage sickle cell: __________ %

Thalassemia genotype: _______________

☐ Sickle cell disease
- ☐ SS
- ☐ SC
- ☐ SB+
- ☐ SB 0
- ☐ Other; specify: _____

☐ Other haemoglobinopathy; specify: ____________________