# 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:** ________________