Putting patients at the HEART of everything we do

NHS
London North West University Healthcare
NHS Trust

Brent Sickle Cell & Thalassaemia Centre
Antenatal Screening and Counselling Form

Client		Partner	
Surname		**Surname**	
First name		**First name**	
Address		**Address**	
Tel		**Tel**	
DoB		**DoB**	
NHS No.		**NHS No.**	
Hospital No.		**Hospital No.**	
GP		**GP**	
Address/Tel.		**Address**	
Ethnic Group		**Ethnic Group**	
Language spoken		**Language spoken**	
Interpreter needed	Yes ☐ • No • ☐	**Interpreter needed**	Yes • ☐ No • ☐
Occupation		**Occupation**	
Religion		**Religion**	

Haematology Results

	Date Tested	Hb Type	Hb	RBC	MCV	MCH	A_2	F	Result to patient	Result to patient for GP
Client										
Partner										

	Yes	No		Yes	No
Is pregnancy IVF	☐	☐	If Yes Donor Egg	☐	☐ • •
If yes was donor tested?	☐	☐ Hb Type (s):……./ ……..	Donor Sperm	☐	☐ •
At risk Couple?	☐	☐ • •	Couple informed of risk?	☐	☐ • •
GP informed of risk?	☐	☐ • •	ANC informed of risk?	☐	☐ • •
Paediatrician forms sent?	☐	☐ •	Lab search form sent?	☐	☐ • •

Obstetric History		**Hospital**			**Consultant**		
LMP	…… / …… / ……	**Gest. Age at testing**	/40	**EDD**	…… /…… / …	**Grav./Para**	

Client prev. counselled	Yes • No •	**Hosp. where tested**		**Where Counselled**		**Hb Result**	
Partner prev. tested	Yes • No •	**Hosp. where tested**		**Date tested**	…… /…... /	**Hb Result**	

Date entered on Database …./…./….

Full Name:	DoB:	NHS No.

Details of Children

Name	DoB	Hospital	M/F	Hb Type	Comments

Counselling Details

Date of appointments: [1] …… / …… / …… [2] …… / …… / …… Gest. age at counselling: ……/ 40

Attended with partner ☐ Attended alone ☐ Partner attended alone ☐ Did not attend ☐

Partner Screening: Blood sample taken ☐ Laboratory forms given / Sent ☐ date sent……

Reason for not attending (*if known*):……

Information discussed	Yes	No	N/A	Client Initial
1. Difference between blood group and Hb type	☐	☐	☐	……
2. What is a red blood cell and its function	☐	☐	☐	……
3. Types of haemoglobin (normal and abnormal)	☐	☐	☐	……
4. Population affected and proportion	☐	☐	☐	……
5. Clinical effect of trait/disease	☐	☐	☐	……
6. Genetic and health implications for nuclear and extended family	☐	☐	☐	……
7. Testing offered to other family members	☐	☐	☐	……
8. Client understanding checked	☐	☐	☐	……

Prenatal Diagnosis

Discussed?	☐	☐	☐	……
Offered?	☐	☐	☐	……
Accepted?	☐	☐	☐	……

If PND not accepted, reason given……..

If PND accepted, name of Dr: …… Centre referred to: ……..... Result of PND: ……..

At risk- couple letter to parents to inform Centre of birth: Yes ☐ No ☐ If no state reason:……

Termination of pregnancy? Yes ☐ No ☐ Gestation when PND Declined:……

Post ToP contact

Outcome of contact: ……..

Neonatal Outcome

Registered Name:…….. DoB: …… / …… / …… Sex: M ☐ F ☐ Lab No: ……

NHS No:…… Neonate Result Hb type: …… Date Parents informed of baby's result:……

PND Centre informed of Neonatal result (*if relevant)*: Yes ☐ No ☐

Brent Sickle Cell & Thalassaemia Centre
(London Northwest University Healthcare NHS Trust)
Antenatal Screening and Counselling Form
(Continuation sheet…..)

Full Name:	**D.o.B:**
Hospital Name:	**Hospital Number:**
NHS Number:	

Date	Comments	Name Signature

Full Name:	DoB:	NHS No.

Date	Comments	Name Signature