Brent Sickle Cell & Thalassaemia Centre
(London Northwest Healthcare NHS Trust)
Neonatal Screening and Counselling Form

DETAILS OF BABY

Birth Surname ……

Registered Surname ……

First Name ……

Address ……..

……

……

Tel. No. ……..……

District ……..

Hospital of Birth …….

D.o.B …../……/…… Sex M ☐ F ☐

Hb Genotype (*final result*)……

Lab No. ……... NHS No. ……

Date card & leaflet sent …. …../…..…../……...

Transfused YES ☐ NO ☐

If **YES** enter date of last transfusion ……/……/……

Affected Baby: Hospital referred…… Name Paediatrician…..……..……....

Date Notified: Parents……..…… GP/ HV……..…….. Date of 1st Hospital Appt.……....

Date 1st prescribed Penicillin:…… Date 1st Primary Vac:……..

HV Details:…….…

……..…

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DETAILS OF PARENTS (Enter surname first in CAPITAL letters, then first name)

Mother …….

DoB ..……/……/…… NHS No:……

Ethnic Origin ……..……

Religion ……..……

GP ……..

Need Interpreter YES ☐ NO ☐

Father ……

DoB ..……/……/…… NHS No:……

Ethnic Origin ……

Religion ……

GP ……..……

Language ……

HAEMATOLOGY RESULTS (Parents) **PND** YES ☐ NO ☐ Outcome:……

	Date Tested	Hb Type	Hb	RBC	MCV	MCHC	A_2	F	Sickle Test	Lab confirmed Yes/No	Screened At
Mother											
Father											

Date(s) card(s) sent: Mother ……/……/…… Father……/……/…… GP notified ……/……/……

DETAILS OF SIBLINGS

Name	DoB	Place of Birth	Sex	Date Tested	Hb Type	Comments

Full Name:	**DoB:**	**Gender:**	**NHS No:**

DETAILS OF COUNSELLING

1.	Date of 1st appointment	……/……..…/…….		
		YES	**NO**	**N/A**
2.	Mother present	☐	☐	☐
3.	Father present	☐	☐	☐
4.	Reason for either, or both parents not attending: ……			
5.	DNA parent offered option of counselling at specialist centre	☐	☐	☐
6.	Mother already aware of Hb genotype	☐	☐	☐
7.	Father already aware of Hb genotype	☐	☐	☐

INFORMATION DISCUSSED DURING COUNSELLING SESSION

8.	Difference between blood group and Hb type	☐	☐	☐
9.	What is red blood cell and its function	☐	☐	☐
10.	Types of haemoglobins - normal/abnormal	☐	☐	☐
11.	Population affected and problems	☐	☐	☐
12.	Clinical effect of trait/disease	☐	☐	☐
13.	Genetic implications for nuclear and extended family	☐	☐	☐
14.	Parental consent for retest (if applicable)		☐	☐

☐

15.	Testing offered to mother:	☐	☐	☐
16.	Testing offered to father	☐	☐	☐
17.	Testing offered to siblings	☐	☐	☐
18.	Parental understanding checked	☐	☐	☐
19.	Contact No. of Centre given	☐	☐	☐
20.	Interaction documented in parent hand-held baby book	☐	☐	☐

If **NO** to any of the above, indicate reason if applicable:……..……....

……

Date	Comments	Signed

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Neonatal Screening and Counselling Form
(Continuation sheet…..)

Full Name:	**Gender:**	**DoB:**	**Ethnic Group:**

Hospital No:	**NHS No:**

Lab No:	**District:**

Date	Comments	Signed

Full Name:	**DoB:**	**Gender:**	**NHS No:**

Date	Comments	Signed