



NATF 116 06
(Relates to SOP NATS MED 016)
**GENETIC HAEMOCHROMATOSIS REFERRAL
FORM FOR ROUTINE BLOOD DONATION**



To refer a patient with genetic haemochromatosis (GH) to SNBTS as potential donor, complete this form and email to NSS.SNBTSdcstadmin@nhs.scot

Email any subsequent medical enquiries to the donor medical team NSS.SNBTSdcst@nhs.scot or contact the donor medical team on 0131 314 5520 (Monday-Friday, 9-3). For more information on GH and blood donation in Scotland, go to www.nss.nhs.scot and search for Haemochromatosis in the search bar.

Section 1. Patient Details				
Surname		Forename(s)		
Date of Birth		Title	Sex	M / F (please select)
Address and Postcode				
Contact Telephone N°				
Has your patient previously donated or registered as a donor with SNBTS?		Blood Donor Registration Number (if known)		
Section 2: Referrer Details				
Name of Referrer				
Job Title				
Address / Telephone				
Name of consultant in charge (Must be provided)				
Email address of referrer for clinical contact (Must be provided)				

Complete Sections 3 and 4 overleaf, then sign below

Declaration

I confirm that:

- The referring clinical team will remain responsible for monitoring ferritin/transferrin saturation and determining venesection frequency
- The referring clinical team will remain responsible for any clinical review or follow up required
- The referring clinical team will offer venesection if the patient is unable to/does not wish to donate blood
- This patient has been informed of the above and has been given contact information for the referring clinical team to discuss venesection if not donating blood

Signed:

Print Name

Date

