Genetics, haemophilia predictive test (known familial variant)

Referring unit (Customer code):

T	5	F	0	A	A

Patient, Name and Date of birth:

Referring physician (Name):

_____

Phone number:

_____

_____

Sample type:

- ◯ EDTA blood
- ◯ Buccal swab
- ◯ Extracted DNA, state tissue of origin *): _____

RESERVED space

*) **N.B.** For **prenatal testing** it is recommended that chorionic villi or amniotic fluid together with a maternal blood sample is sent directly to Clinical Genetics, Lund. If this is not possible, it is mandatory to state the **sex of the foetus** and that **maternal contamination** has been excluded. Please provide this information in "Clinical history" below.

Haemophilia, predictive test (known familial variant)

Previous referrals:

Family number:

_____

Index individual / positive control (Name, DOB):

_____

Familial variant:

_____

Sex:

- ◯ Female
- ◯ Male

Haemophilia type:

- ◯ Haemophilia A
- ◯ Haemophilia B

Coagulant activitity:

FVIII:C _____

FIX:C _____

Inhibitor FVIII / FIX ?

- ◯ Yes
- ◯ No

Degree of severity:

- ◯ Severe
- ◯ Moderate
- ◯ Mild

Clinical history (including any family members with haemophilia):

Sample date and time:

Biobank:
The referring unit is hereby informed that the sample will be stored in the biobank in accordance with Swedish regulations.
Please contact the laboratory if permission is not granted or withdrawn.

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Clinical Genetics
SE-221 85 Lund
Sweden
tel: +46-(0)46-17 33 62