Genetics, haemophilia screening (diagnostic analysis)

Referring unit (Customer code)**:**

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Referring physician (Name)**:**

Phone number:

Patient, Name and Date of birth:

Sample type:

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

RESERVED space

Haemophilia, genetic screening (diagnostic analysis, unknown familial variant)

Requested genetic analysis:

- ◯ Screening of the *F8* gene
- ◯ Screening of the *F9* gene

Sex:

- ◯ Female
- ◯ Male

Family number (if known): _____

Haemophilia type:

- ◯ Haemophilia A
- ◯ Haemophilia B

Coagulant activity:

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Please contact the laboratory if permission is not granted or withdrawn.

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REGION SKÅNE