

# FAMILY ORIGIN QUESTIONNAIRE



Place labelled specimens in bag, remove protective strip, fold flap onto bag and seal firmly.

JB-122717

## ANTENATAL BOOKING REQUEST

Please use a ball point pen. Print Firmly

What are your family origins?

### Family Origin Questionnaire

Is the pregnancy the result of IVF? If yes, complete the form including SECTION H  
Please tick all boxes in ALL sections that apply to the woman and the baby's biological father

#### A. AFRICAN OR AFRICAN-CARIBBEAN (BLACK)

- Caribbean Islands
- Africa (excluding North Africa)
- Any other African family origins

- India or African-Indian
- Pakistan, Bangladesh, Sri Lanka

#### B. SOUTH ASIAN (ASIAN)

#### C. SOUTH EAST ASIAN (ASIAN)

- China including Hong Kong, Taiwan
- Singapore, Thailand, Indonesia
- Malaysia, Vietnam, Philippines
- Cambodia, Laos, Myanmar
- Any other Asian family origins

#### D. OTHER NON-EUROPEAN (OTHER)

- North Africa, South America
- Middle East, Saudi Arabia, Iran
- Any other Non-European family origins

#### E. SO LUTHERN AND OTHER EUROPEAN (WHITE)

- Sardinia
- Greece, Turkey, Cyprus
- Italy, Portugal, Spain
- Albania, Czech Republic
- Poland, Romania, Russia
- Any other Mediterranean country

#### F. UNITED KINGDOM (WHITE)

- England, Scotland, Northern Ireland, Wales

#### G. NORTHERN EUROPEAN (WHITE)

- Austria, Belgium, Switzerland, Scandinavia
- ire, France, Germany, Netherlands
- Australia, North America, South Africa
- Any other European family origins

#### \*Hb Variant Screening Requested by (F) and/or (G)

# High her risk for alpha zero thalassaemia

#### H. DON'T KNOW

Adoption/unknown ancestry

Donor egg/sperm (if pregnancy results from donor egg, order test for mother and offer biological father test immediately)

Bone marrow transplant (if mother has had a bone marrow transplant, order test for mother and offer biological father test immediately)

#### I. DECLINED TO ANSWER

TOP COPY - To Haematology 2nd COPY - To Microbiology 3rd COPY - To Transfusion 4th COPY - To Maternity  
The completion of this form is an ESSENTIAL part of the NHS Screening Programme for sickle cell & thalassaemia

## ANTENATAL BOOKING REQUEST

Lab Sample Numl

NHS No. ....

Hospital No. ....

Surname .....

Forename .....

Address .....

Post Code .....

Date of Birth ...../...../..... Ward/Location .....

GP Name ..... GP Code .....

EDD ..... Gestation .....

Urgent

Haemoglobinopathy screen Offered & Accepted  Declined

FBC Offered & Accepted  Declined

Microbiology/Virology Offered & Accepted  Declined  Known Posi

Hepatitis BsAg

HIV

Syphilis

Rubella IgG

Reason for Decline Known positive (Attach Biohazard sticker) Patient Choice

#### Blood Transfusion

Group and Antibodies

Previous pregnancies Y/N Blood group if known .....

Antibodies Y/N Type .....

Previous transfusion Y/N Reaction Y/N

Anti D prophylaxis Y/N Date given .....

Booking

Person Completing this form .....

Patient Identified & Bled by (signature) .....

Print name .....

Date & Time bled .....