CONFIDENTIAL

NOTIFICATION OF THALASSAEMIA

NOTE:
This notification form is to be completed for every case of Thalassaemia.
Please forward the completed form to:

NATIONAL THALASSAEMIA REGISTRY
LEVEL 6 CHILDREN'S TOWER
KK WOMEN'S AND CHILDREN'S HOSPITAL
100 BUKIT TIMAH ROAD SINGAPORE 229899
Tel: 6394 1863 or 6394 1864 Fax: 6394 1867
Email: Nat.Thal.Reg@kkh.com.sg

A copy of the FBC and Hb Electrophoresis results of the patient should accompany this notification.

I – PARTICULARS OF PATIENT

1. Name : ……..
2. NRIC/BC No. : ☐ ☐☐☐☐☐☐☐☐ ☐
3. Date of Birth : ☐☐ ☐☐ ☐☐ *Day Mth Yr*
4. Sex : ☐ Male ☐ Female
5. Race : ☐ Chinese ☐ Malay ☐ Indian ☐ Others
6. Marital Status : ☐ Single ☐ Married ☐ Divorced / Separated ☐ Widowed
7. Address : ……Postal Code: ……
8. Tel No. : ……(Home)…. ……..(Handphone)……(Office)
9. DIAGNOSIS : ☐ α Thalassaemia ☐ β Thalassaemia ☐ Others……..

II - FAMILY HISTORY

Please provide information on the family of the patient and the results of screening for Thalassaemia if available in the form of a Family Tree.
[Staff of the Registry may contact you for further details.]

III - INFORMED CONSENT (This section MUST be filled by patient or next-of-kin of patient)

a) I consent for notification to the National Thalassaemia Registry (NTR).
b) I agree to allow NTR staff access to my/ my child's medical information.
c) I consent to be contacted by the NTR staff for further counselling and screening for me and my family members.

Name: _____Signature: _____Date:_____

IV – NOTIFYING DOCTOR

Name of Notifying Doctor: …… Designation : ……

Hospital / Clinic : …… Tel No. : ……

Date of Notification : ☐☐ ☐☐ ☐☐ *Day Mth Yr* Signature : ……