Screening for Haemoglobinopathies
Family Origin Questionnaire (FOQ)

Hospital Name ....
CHI No. ....
Estimated Delivery Date ....
Surname ....
Forename ....
Date of Birth ....
Address 1 ....
Address 2 ....
Postcode ....

Screening test declined ☐

This form must be attached securely to the haematology laboratory request form with the antenatal blood samples. A second copy of the form should be added to the patient's maternity record. (A third copy can be added to the hospital records if applicable). The completion of this form is an ESSENTIAL part of the screening process.

What are your family origins?

Please tick all boxes in ALL sections that apply to the woman and the baby's father

		Woman	Baby's father
A.	**AFRICAN OR AFRICAN CARIBBEAN (BLACK)**		
1/	Caribbean Islands	☐	☐
2/	Africa (excluding North Africa)	☐	☐
3/	Any other African or African-Caribbean family origins (please write in…)		
B.	**SOUTH ASIAN (ASIAN)**		
1/	India or African-Indian	☐	☐
2/	Pakistan	☐	☐
3/	Bangladesh	☐	☐
C.	**SOUTH EAST ASIAN (ASIAN)**		
1/	China including Hong Kong, Taiwan, Singapore	☐ #	☐ #
2/	Thailand, Indonesia, Burma	☐ #	☐ #
3/	Malaysia, Vietnam, Philippines, Cambodia, Laos	☐ #	☐ #
4/	Any other Asian family origins (eg Caribbean-Asian) (please write in…)		
D.	**OTHER NON-EUROPEAN (OTHER)**		
1/	North Africa, South America etc	☐	☐
2/	Middle East (Saudi Arabia, Iran etc)	☐	☐
3/	Any other Non-European family origins (please write in….)		
E.	**SOUTHERN & OTHER EUROPEAN (WHITE)**		
1/	Sardinia	☐ #	☐ #
2/	Greece, Turkey, Cyprus	☐ #	☐ #
3/	Italy, Portugal, Spain	☐	☐
4/	Any other Mediterranean country	☐	☐
5/	Albania, Czech Republic, Poland, Romania, Russia etc	☐	☐
F*	**UNITED KINGDOM (WHITE) refer to guidance at the back**		
1/	England, Scotland, N Ireland, Wales	☐	☐
G*	**NORTHERN EUROPEAN (WHITE) refer to guidance at the back**		
1/	Austria, Belgium, Ireland, France, Germany, Netherlands	☐	☐
2/	Scandinavia, Switzerland etc	☐	☐
3/	Any other European family origins, refer to chart (eg Australia, N America, S Africa) (please write in…)		
	*Hb Variant Screening Requested by F and/or G *(ie request from low risk group)*	☐	☐
	# Higher risk for alpha zero thalassaemia		
H.	**DON'T KNOW (incl. pregnancies with donor egg/sperm)**	☐	☐
I.	**DECLINED TO ANSWER**	☐	☐
J.	**ESTIMATED DELIVERY DATE (please write in if not above)**		
K.	**GESTATION AT TIME OF TEST**		

OFFER haemoglobin variant screening to all women if they or their baby's father have answers in a shaded box

Signed ____________________ Print Name ____________________

Job Title ____________________ Contact Tel No ____________________ Date ____________________

(By Health Care Professional completing the form)