# HAEMOGLOBINOPATHIES

## DISEASE

**Note: complete this form only if this diagnosis was the indication for the HCT/GT or if it was specifically requested. Consult the manual for further information.**

**Date of diagnosis/date of first event:** _ _ _ _ / _ _ / _ _ *(YYYY/MM/DD)*

**Classification:**

☐ Thalassaemia; **Type**:
- ☐ β0 / β0
- ☐ β0 / β+
- ☐ β0 / βE
- ☐ β+ / βE
- ☐ β+ / β+
- ☐ Other; specify: _____

☐ Sickle cell disease; **Type**:
- ☐ SS
- ☐ SC
- ☐ SB+
- ☐ SB0
- ☐ Other; specify: _____

☐ Other haemoglobinopathy; specify: ____________________