

ALL DETAILS AND INFORMATION WILL BE KEPT ON OUR COMPUTERS AND WILL REMAIN IN THE OFFICE AND WILL NOT BE MADE AVAILABLE TO ANYBODY OUTSIDE OF THE UKTS.

If however you do not wish your details kept on our computers please tick this box

Charity Reg No: 275107

YOUR PERSONAL DETAILS

Title (Mr/Mrs/Miss/Ms/Other)
First Name/s
Surname
Address
.....
.....
.....
Post Code

CONTACT DETAILS

Telephone: Home
Work
Mobile
Fax:
E-mail:

Are you a: Patient
Parent/Relative
Health care professional
Association
Other (Please state)

Occupation
Ethnic Origin (optional)

MEMBERSHIP REQUIRED: (please tick) ANNUAL LIFE (Annual £10.00 Life £100.00)
(Please make your cheque payable to U.K.T.Society)

IF YOU ARE A PATIENT OR PARENT OF A PATIENT PLEASE COMPLETE THE SECTION BELOW.

Patient's first name/s Date of birth: Male Female

Type of thalassaemia: (e.g. Major, Intermedia, Haemoglobin H etc)

Hospital where treated:

Hospital address:
.....
.....

Consultant's Name:

Consultant's Telephone Number:

GP's Name:

GP's Address:
.....

GP's Telephone Number:

BLOOD TRANSFUSED: Whole Washed Frozen Filtered **CHELATION:** Desferal Deferiprone Desferal & Deferiprone

(Please tick) (Please tick)

Transfusion Frequency: Units received at each transfusion Blood Type:

OFFICE USE: DATE PAID RECEIPT No APPROVAL DATE