

Your family's genetic makeup may influence your child's future health. Having your family's ancestry is important to us when interpreting the findings of these tests. Please refer to the country key when answering the questions below.

Family/Ancestral Questionnaire

Woman's details	Partner's details
Given name:	Given name:
Family name:	Family name:
Date of birth:	Date of birth:
Address:	Address:
Medicare number:	Medicare number:

Is there a known family history of thalassaemia and/or haemoglobin variant?

(e.g. sickle cell haemoglobin, haemoglobin E or C)

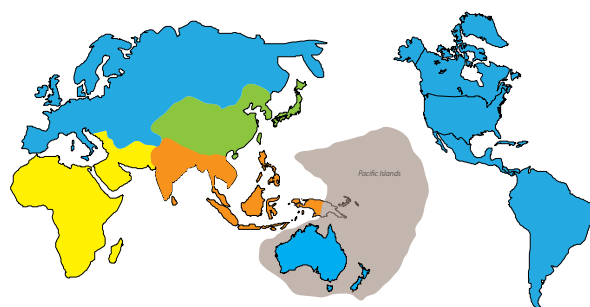
Woman Yes No Not sure

Partner Yes No Not sure

What are your or your family's origins?

Please tick *all* boxes that apply.

Region of family/ancestral origin	Woman	Partner
Caucasian - United Kingdom Europe/North America/Australia	<input type="checkbox"/>	<input type="checkbox"/>
Aboriginal - Torres Strait islanders/Pacific Islands	<input type="checkbox"/>	<input type="checkbox"/>
South Asian - including the Indian subcontinent	<input type="checkbox"/>	<input type="checkbox"/>
Oriental - Japan, Taiwan, Korea and China	<input type="checkbox"/>	<input type="checkbox"/>
Afro-Caribbean - Africa/Middle East/other African origins	<input type="checkbox"/>	<input type="checkbox"/>



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EDC:	Consanguinous Couple <input type="checkbox"/> Yes <input type="checkbox"/> No
Gestation:	If yes: Relationship _____
UR number:	Current Pregnancy: IVF <input type="checkbox"/> Yes <input type="checkbox"/> No
Location:	If yes: Donor Egg <input type="checkbox"/> Yes <input type="checkbox"/> No
(Hosp. Shared Services, Dr's rooms)	Donor Sperm <input type="checkbox"/> Yes <input type="checkbox"/> No