

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 .....