STATE BLOOD TRANSFUSION COUNCIL, MUMBAI

REGISTRATION FORM

(Thalassaemia / Heamophilia / Sickle cell)

2 photos

Name of patient:			
Age:		Date of birth:	
Sex: ☒ Male ☐ Female		Blood Group:	
Identification Mark:			
Detailed address:			
Name of the institution where patient is taking treatment at present:			
Detailed address of institution:			
Date of Diagnosis of the disorder (T/H) Date / Year:			
Final Diagnosis:			

DETAILS OF TREATMENT (AT PRESENT)

Blood:	
Tabs/ Capsules:	
Injection:	
Others:	

Whether vaccinated for Hepatitis-B: ☒ Yes ☐ No

NAME OF OTHER INSTITUTIONS / SOCIAL ORGANIZATION WHERE THALASSAEMIA PATIENTS ARE TREATED.

a:		b:	
c:		d:	

NAME OF THE BLOOD BANK IN MUMBAI, WHERE BLOOD COMPONENT SEPARATION FACILITY IS AVAILABLE.

Dr. Name:	
Dr. Signature with stamp:	

Note: Name & Signature of Doctor is must for enabling this office to prepare Identity Card.