Patient information

www.cbtmed.de

You and your health are our main focus

You can find here all important information concerning your first visit at CBT

1. Please bring the following documents, this equally applies to those with statutory health insurance as well as private insurance:
   - **your health insurance card**
   - **a referral from your family doctor or medical specialist for the recent quarter**
   - **current diagnostic findings, if existent**
   - **completed CBT-patient questionnaires**

     If you are not able to print out the questionnaires yourself, we ask you to come 30 minutes prior to your appointment, and you will receive the questionnaires on site.

     Completed questionnaires in digital form should be send directly to fragebogen@cbtmed.de.

     Your personal data will be treated in the strictest confidence and in compliance with current data protection guidelines. We will not forward your email address to any third party.
2. Please eat and drink sufficiently before blood sample collection – do not attend your appointment on an empty stomach.
3. We would like you to let us know if you do not tolerate the blood collection. In this case, we can take some preventive measures.

If you take anticoagulants regularly and/or permanently, please pay attention to the following information prior to blood collection

Last medication intake according to prescription	ASA / Clopidogrel	Rivaroxaban	Edoxaban	Dabigatran	Apixaban
	Macumar	Xarelto®*	Lixiana®	Pradaxa®	Eliquis®
	no pause	24hrs. before appointment		12 hrs. before appointment	

*Note: This pause only applies if you take **1x 20 mg Xarelto®** per day. If you take **2x 15 mg Xarelto®** (e.g. after a thrombotic event in the last three weeks), it is advisable to postpone the appointment until the dose is reduced to 1x 20 mg per day. **Please consult your doctor!**

If you use heparin (e.g.: Clexane®, Fragmin®, Arixtra®), you may administer it to yourself as usual (morning injections), ideally approx. 3-4 hours before the blood collection for the purpose of laboratory monitoring (drug effectiveness test).

Please bring your OAC (e.g. Xarelto® and Eliquis®) to your appointment, so you may take it after blood collection as usual.

If you have any further questions, please do not hesitate to contact us by phone: +49 228 201 800, Mon.-Fri. 8.00am - 4.30pm.

Your CBT-Team

004 + 303-Version 3.0 (02/2024)-F034_e

Admission and Medical History

www.cbtmed.de

Patient's data

Any preliminary findings?

If yes, bring this with you.

Date: _____

Patient

Last Name, First Name | Date of Birth

Street Address

Postal code, City

Phone | Phone Office

Mobil

E-Mail

Profession

Health Insurance

Reason for referral (to be filled out by the doctor)

Transferring Physician

Name

Street

City

Fax

Patients with private insurance

Last Name, First Name

Address (Please provide Insurance Policy owner, if different than address above.)

Referring Physician

Name

Street

City

Fax

Height ..... Weight ..... BMI .....

Blood type .....

RR: ..... Pulse rate: .....

Blood: Date/time ..... Implemented by (abbreviation): .....

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Continuation of Medical History (to be filled out by the doctor)

Medication	Dosage	Taken last?
Direct oral anticoagulants ☐ Xarelto® (Rivaroxaban) ☐ Eliquis® (Apixaban) ☐ Lixiana® (Endoxaban) ☐ Pradaxa® (Dabigatran)		
Heparin ☐ Clexane ☐ Fragmin ☐ Other:		
Vitamin K antagonists ☐ Marcumar® ☐ Coumadin® ☐ Other:		
Antiplatelet agents ☐ Aspirin, ASS ☐ Clopidogrel (Plavix®, Iscover®) ☐ Prasugrel (Efient®) ☐ Ticagrelor (Brilique®)		

PatID

I. Current and known diseases

Please answer the following questions as carefully as possible.

1. Do you currently have bronchitis or a feverish cold? ☐ Yes ☐ No

2. Do you currently have an infection? ☐ Yes ☐ No
   What type of infection? .....

3. Allergy ☐ Yes ☐ No
   Please list all known allergies: .....

4. Diabetes ☐ Yes ☐ No

5. Liver disease (e.g. hepatitis) ☐ Yes ☐ No
   What type of liver disease? .....

6. Kidney disease ☐ Yes ☐ No
   What type of liver disease? .....

7. Heart disease ☐ Yes ☐ No
   What type of heart disease?
   ☐ Heart attack When: .....
   ☐ Heart rhythm disturbances When: .....
   ☐ Other heart disease: ..... When: .....
   Please list any lasting side effects from your heart disease: .....

8. Have you been diagnosed with an autoimmune disease? ☐ Yes ☐ No
   What disease? .....
   Are you or have you been treated for this? ☐ Yes ☐ No
   Please describe the treatment received: .....

9. Hypertension (high blood pressure) ☐ Yes ☐ No
   What was your last reading (approx.)? ...../.....

10. Elevated blood fat levels (e.g. cholesterol) ☐ Yes ☐ No
    What was your last value (approx.)? .....

11. Do you have frequent joint pain? ☐ Yes ☐ No

12. Transient Ischemic Attack (TIA), a minor stroke that lasts less than 24 hrs. ☐ Yes ☐ No
    When? .....
    Please list any lasting side effects from your TIA: .....

13. Stroke ☐ Yes ☐ No
    When? .....
    Please list any lasting side effects from your Stroke: .....

14. Vascular disease (e.g. arteriosclerosis) ☐ Yes ☐ No
    What disease? .....

Continued from previous page

15. Varicose veins ☐ Yes ☐ No
    If yes, are you or have you been treated for this? ☐ Yes ☐ No

16. Do you or did you have any other disease or medical condition? Please list or describe:

    .....

    .....

    .....

17. Do you smoke cigarettes? ☐ Yes ☐ No
    If so, how many cigarettes daily? ..... For how many years? .....

18. How much alcohol do you drink on average?
    Per week approximately ..... Per month approximately .....

II. Medications

1. Have you taken acetylsalicylic acid in the last 7 days? (e.g. ASS, Aspirin) ☐ Yes ☐ No
   Which one? ..... Dosage: ..... When was the last dose? .....

2. Have you taken Clopidogrel in the last few days? (Plavix, Iscover) ☐ Yes ☐ No
   Which one? ..... Dosage: ..... When was the last dose? .....

3. Do you take Marcumar or Warfarin? (or other anticoagulants) ☐ Yes ☐ No
   Which one? ..... Dosage: ..... Since when? ..... (month/year)

4. Do you inject heparine? ☐ Yes ☐ No
   Which one? ..... When was the last dose? ..... (time)

5. Have you taken any pain medication or rheumatism drug during the last 10 days? (e.g. Ibuprofen) ☐ Yes ☐ No
   Which one? .....

6. Do you take any other medication regularly ? ☐ Yes ☐ No
   Please list the medication, dosage and frequency:

Medication	Dosage

III. Thrombosis and Embolism

Note: If you ever had one oder more thromboses/lung embolism, please anwer the following questions for each.

If not → please continue on page 6.

1. Thrombosis	2. Thrombosis	3. Thrombosis	4. Thrombosis
1. When (month/year) did you have the first thrombosis or further thrombosis?			
..... /	..... /	..... /	..... / .....
2. Check the appropriate box that best describes your thrombosis? Please tick as appropriate			
☐ Superficial thrombosis (phlebitis) ☐ Muscular vein thrombosis ☐ Deep vein thrombosis ☐ Portal vein thrombosis ☐ Pulmonary embolism ☐ I don´t know.	☐ Superficial thrombosis (phlebitis) ☐ Muscular vein thrombosis ☐ Deep vein thrombosis ☐ Portal vein thrombosis ☐ Pulmonary embolism ☐ I don´t know.	☐ Superficial thrombosis (phlebitis) ☐ Muscular vein thrombosis ☐ Deep vein thrombosis ☐ Portal vein thrombosis ☐ Pulmonary embolism ☐ I don´t know.	☐ Superficial thrombosis (phlebitis) ☐ Muscular vein thrombosis ☐ Deep vein thrombosis ☐ Portal vein thrombosis ☐ Pulmonary embolism ☐ I don´t know.
☐ Lower leg ☐ Thigh ☐ Pelvic veins ☐ Arm veins ☐ Calvicular vein ☐ Sinus veins (head) ☐ Lungs Other:	☐ Lower leg ☐ Thigh ☐ Pelvic veins ☐ Arm veins ☐ Calvicular vein ☐ Sinus veins (head) ☐ Lungs Other:	☐ Lower leg ☐ Thigh ☐ Pelvic veins ☐ Arm veins ☐ Calvicular vein ☐ Sinus veins (head) ☐ Lungs Other:	☐ Lower leg ☐ Thigh ☐ Pelvic veins ☐ Arm veins ☐ Calvicular vein ☐ Sinus veins (head) ☐ Lungs Other: .....
☐ Left side of the body ☐ Right side of the body	☐ Left side of the body ☐ Right side of the body	☐ Left side of the body ☐ Right side of the body	☐ Left side of the body ☐ Right side of the body
3. How was the thrombosis and/or lung embolism diagnosed? Through ...			
☐ ultrasound scan ☐ contrast medium exami nation (x-ray)	☐ ultrasound scan ☐ contrast medium exami nation (x-ray)	☐ ultrasound scan ☐ contrast medium exami nation (x-ray)	☐ ultrasound scan ☐ contrast medium exami nation (x-ray)
☐ nuclear medicine exam ☐ computer tomography CT	☐ nuclear medicine exam ☐ computer tomography CT	☐ nuclear medicine exam ☐ computer tomography CT	☐ nuclear medicine exam ☐ computer tomography CT
4. Before you had the thrombosis/embolism, were you sitting (on a trip) for more than 4 hours?? If yes, how did you travel?			
☐ by car ☐ by plane	☐ by car ☐ by plane	☐ by car ☐ by plane	☐ by car ☐ by plane
5. Before you had the thrombosis/embolism, were you immobile for a long period of time? If yes, check the appropriate reason and length of time:.			
☐ Hospital stay ☐ Surgery ☐ Plaster cast on leg or foot ☐ Injury: ..... ☐ Other:	☐ Hospital stay ☐ Surgery ☐ Plaster cast on leg or foot ☐ Injury: ..... ☐ Other:	☐ Hospital stay ☐ Surgery ☐ Plaster cast on leg or foot ☐ Injury: ..... ☐ Other:	☐ Hospital stay ☐ Surgery ☐ Plaster cast on leg or foot ☐ Injury: ..... ☐ Other: .....
How long:	How long:	How long:	How long: .....

Continued from previous page

1. Thrombosis	2. Thrombosis	3. Thrombosis	4. Thrombosis
6. Did you have an infection or fever in the weeks before the thrombosis?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7. Did you have any unusual physical stress before the thrombosis? ☐ Yes ☐ No Please describe the stress:			
.....	.....	.....	.....
.....	.....	.....	.....
8. Did you have a tumor when the thrombosis/embolism occurred?? What type of tumor?			
.....	.....	.....	.....

IV. Bleeding Issues

1. Do you bleed often? ☐ Yes ☐ No

   If yes, what part of the body? How often?

   ....

   ....

2. When you have an incised wound or an abrasion is it dfficult to stop the bleeing? ☐ Yes ☐ No

3. Do you have problems with healing of wounds? ☐ Yes ☐ No

4. Do you notice increased bleeding gums? ☐ Yes ☐ No

   If yes, on which occasions?

   ☐ When brushing the teeth
   ☐ During dental treatment (e.g. extraction of teeth)
   ☐ Without apparent reason

5. Do you bruise easily from minor interactions? ☐ Yes ☐ No

   If you bruise easily, please answer the following questions.

Where?	How often?	Since? (month/year)
☐ Arms	.....	..... / .....
☐ Legs	.....	..... / .....
☐ Body	.....	..... / .....

Continued from previous page

6. Do you have frequent nose bleeds? ☐ Yes ☐ No

If yes,

a) How often do you have nose bleeds?

☐ several times a year ☐ several times a month ☐ several times a week Since? ...../......... (month/year)

b) Which side?

☐ right nostril ☐ left nostril ☐ both nostrils

c) Do you have nose bleeds without any apparent reason? ☐ Yes ☐ No

d) Did you consult an Ear Nose and Throat (ENT) doctor for your nose bleeds? ☐ Yes ☐ No

If yes, what was the reason for the nose bleeds? ....

Did the doctor make a sclerosis? ☐ Yes ☐ No

Did the doctor make a tamponade? ☐ Yes ☐ No

7. Have you ever noticed blood in your urine or stools? ☐ Yes ☐ No

If yes, what was the cause? ....

8. Have you ever had stomach bleeding? ☐ Yes ☐ No

9. Have you ever been diagnosed with „blood clotting disorder" (e.g. hemophilia)? ☐ Yes ☐ No

If yes, what disorder? ....

10. Did the bleeding tendency become worse after taking a medication (e.g. painkiller)? ☐ Yes ☐ No

If yes, which medication? ....

11. Have you had any Surgical Procedures or Operations? ☐ Yes ☐ No

If yes, please complete the table below and answer the corresponding question for each procedure:

a) Was there serious bleeding within the first hours following the operation?

b) Was there serious bleeding within the first few days following the operation?

c) Did you receive a blood transfusion due to excessive bleeding?

d) When (month/year) was the operation?

Surgical Procedure (incl. wisdom teeth)	a) bleeding within the first few hours	b) bleeding within the first days	c) Transfusion required	d) When? (month/year)
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	...... / ....
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	...... / ....
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	...... / ....
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	...... / ....
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	...... / ....
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	...... / ....
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	...... / ....

12. Is a surgical procedure planned in near future? ☐ Yes ☐ No

What type of procedure? ....

When? (Please provide the exact date) ....

V. Family Medical History

Inherited blood coagulation disorder

1. How many (biological) children do you have? .....

   Provide their year of birth: Child 1. ..... 2. ..... 3. ..... 4. ..... 5. ..... 6. .....

2. How many siblings (include half-siblings) do you have? .....

   Provide their year of birth: Sibling 1. ..... 2. ..... 3. ..... 4. ..... 5. ..... 6. .....

3. Is someone in your immediate family (parents, siblings) diagnosed or afflicted with a thrombosis or bleeding issues? ☐ Yes ☐ No

   If yes, please complete.

   a) Which family member?
   (if grandparents, please complete if paternal (p) or maternal (m))

   b) At which age did the thrombosis/tendency to bleed occur?

   c) Did he/she take medication against the thrombosis, e.g. Marcumar?.

Family member	had at the age of	thrombosis	tendency to bleed	took Marcumar or so
	..... years	☐	☐	☐
	..... years	☐	☐	☐
	..... years	☐	☐	☐
	..... years	☐	☐	☐
	..... years	☐	☐	☐

4. Have other relatives (uncle, aunt, cousin) ever had a thrombosis or bleeding issues? ☐ Yes ☐ No

   If yes, please complete.

Family member	thrombosis	bleeding issue
	☐	☐
	☐	☐
	☐	☐

Thank you very much for answering the questions!

V. Familienanamnese

zur Abklärung einer **angeborenen** Gerinnungsstörung

1. Wie viele (eigene) Kinder haben Sie? _____ Kinder

   Geburtsjahr der Kinder: 1. Kind:_____(w/m/d) 2. Kind:_____(w/m/d) 3. Kind:_____(w/m/d)
   4. Kind:_____(w/m/d) 5. Kind:_____(w/m/d) 6. Kind:_____(w/m/d)

2. Wie viele Geschwister (auch Halbgeschwister) haben Sie? _____ Geschwister

   Geburtsjahr der Geschwister: 1. Geschw.: _____ 2. Geschw.: _____ 3. Geschw.:_____
   4. Geschw.: _____ 5. Geschw.: _____ 6. Geschw.:_____

3. Hatte jemand in Ihrer engeren Familie schon einmal eine Thrombose oder Blutungsneigung (siehe Definition Seite 5)? ☐ ja ☐ nein
   (engere Familie = Sohn, Tochter, Bruder, Schwester, Vater, Mutter, Großvater, Großmutter)

   Wenn ja, schreiben Sie bitte in die Tabelle:

   a) Welches Familienmitglied?
   (wenn Großeltern, geben Sie bitte auch an, ob väterlicherseits (V) oder mütterlicherseits (M))

   b) Wie alt war das Familienmitglied, als es die Thrombose/Blutungsneigung bekam?

   c) Hat das Familienmitglied ein Medikament gegen die Thrombose eingenommen, z.B. Marcumar?

Familienmitglied	hatte im Alter v.	Thrombose	Blutungsneigung	nahm Marcumar o.ä.
	..... Jahren	☐	☐	☐
	..... Jahren	☐	☐	☐
	..... Jahren	☐	☐	☐
	..... Jahren	☐	☐	☐
	..... Jahren	☐	☐	☐

4. Hatten andere Verwandte bereits eine Thrombose oder Blutungsneigung? ☐ ja ☐ nein
   Wenn ja, schreiben Sie bitte in die Tabelle, welcher Verwandte (z.B. Onkel, Cousin ....)
   und kreuzen Sie an, ob es eine Thrombose oder Blutungsneigung war.

Verwandte	Thrombose	Blutungsneigung
	☐	☐
	☐	☐
	☐	☐

Vielen Dank für Ihre Mitarbeit!

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Health insurance

Name, first name of the insured person

born on

Health insurance number | insurance number | status

Establishment number | physician number | date

(Adressfeld entspricht Überweisungsscheinformat. Ausfüllen mit Drucker möglich.)

Sex of the patient:

☐ male ☐ female ☐ undefined

Ethnical origin .....

Stamp

www.cbtmed.de

Consent to human genetic analyses conformable to Genetic Diagnostics Act (GenDG)

- I have been informed by the examining physician about the examination and their importance. I have understood this information and had enough time to think about my decision and I agree with the genetic analyses.
- I am aware that I can withdraw my consent at any time in written or oral way to the attending physician affecting future analyses. An oral withdrawal is documented immediately and will be transmitted to the examining laboratory.
- I agree to forward the investigation remit to a cooperating specialized medical laboratory if required as well as to the communication of results for medical evaluation.
- I want to be informed about incidental findings within the context of this examination if they are relevant for my health or the health of my blood relatives.
- I agree that the results will be stored longer than the statutory period of 10 years. There is no claim for retention.
- I agree that collected data and results are documented anonymised for quality assurance.
- According to the Genetic Diagnostics Act, unused specimen has to be destroyed after 10 years or at your request immediately. Hereby, I agree that my genetic material (DNA) is stored for longer than this legal period of 10 years and is archived for later genetic analyses. I re-assign any residual genetic material to the examining laboratory in anonymous form for quality assessment or research purposes.

I read and understood this text. I agree with all mentioned points.

My family doctor/ specialist should receive a report. I receive a report as well.

(crossout inapplicable)

I received a copy of this form.

..... X .....

Place, date | Signature patient/ legal representative

.....

Signature physician

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Notice of patient information

www.cbtmed.de

Report

As soon as all laboratory results are available, your physician will write a report letter based on results, the information from your questionnaire and your interview with him. This report letter includes diagnoses, assessment and therapeutic recommendations.

This letter will then be sent by post to your home or electronically to you, and if possible electronically via the telematics infrastructure to your GP or referring doctor.

☐ I have an e-mail address (see page 2) and agree that the practice may send me my documents by e-mail.
If necessary, only transport encryption and no content encryption will be used for sending.

Agreement on data transfer

By accepting this agreement, you voluntarily acknowledge and consent to the use and transfer of personal data to third parties. However, failure to provide the consent may affect the best possible treatment with us or with other physicians. Possible third parties could be your physicians/hospitals and relatives, partners, children or others.

1. Name referring doctor: _____

2. Name general practitioner: _____

3. Name physiotherapist: _____

4. Name midwife: _____

5. Name psychologist: _____

6. Relative / third person:

last name	first name	date of birth

☐ **No** If you do not agree with data transfer to third parties.

Agreement to request of reports by general practicioner, medical specialists or hospitals.

I agree ☐ yes ☐ no

Agreement to data transfer fort appointments at physicians or hospitals.

I agree ☐ yes ☐ no

Notice of patient information

www.cbtmed.de

Data privacy statement

I have taken note of the data protection declaration, with reference to the information and complaint form for personal data, which is available in the waiting area and on the homepage www.cbtmed.de. I am informed that I can revoke my consent in writing at any time for future processing in accordance with Art. 7 DS-GVO.

Patient:

last name

first name

date of birth

e-mail

street address

city

For minors and patients requiring care statutory representative:

last name

first name

date of birth

e-mail

street address

city

city, date

X signature patient/statutory representative

Consent to appointment reminders via SMS or e-mail

In order to avoid missed appointments, we would like to remind you of your appointment by sending you an SMS and / or e-mail using the Doctolib calendar system. Please confirm your agreement with your signature.

☐ **Yes** I would like to receive an appointment reminder.

☐ e-mail (see above) or ☐ Mobile phone number:

I am informed that I can revoke my consent for future processing in accordance with Art. 7 GDPR (General Data Protection Regulation) in written form at any time.

city, date

X signature patient/statutory representative

☐ **No** I do not want to receive any appointment reminders.

I have received a copy of this form.

X signature patient/statutory representative

Additionally for PRIVATE INSURED

www.cbtmed.de

Transfer of personal data
Consent form

Please paste patient label

Dear patient,

Subsequently to your examinations and if applicable your treatments at CBT-Group (CBT Bonn MVZ GmbH mit Zweigstelle Wuppertal, CBT Dortmund GmbH, CBT AHV MVZ GmbH Alfter mit Zweigstelle Düsseldorf, Standort Köln) hereinafter referred to as CBT, you will receive a bill.

To minimize administrative efforts the liquidation is performed by ABV (society of physicians accounting – economic counseling – compensation systems GmbH, 45740 Mühlheim a.d. Ruhr, Obere Saarlandstraße 3 and 76255 Ettlingen, Weberstraße 55) in the name of CBT.

Therefore, ABV is your contact for issues concerning outstanding receivables. Because of the cession of medical fees, CBT will only act as a witness in arguable processes. If there are any disagreements you have to deal with ABV. However, the bill will be compiled following instructions of CBT and there will be no additional costs.

To set up the bill a transfer of your personal data like address, date of birth, insurance company, dates of treatment, provided services and diagnoses to ABV is necessary.

All information will be treated considering data safety regulations of the invoicing company. The company is under an obligation to ensure confidentiality and will treat any information confident and use them only for billing and collection.

Hints about costs and absorption of costs

You are obligated to pay the bill of CBT, if your private health insurance does not cover the costs of your treatment and other provided services.

The costs for the examination of a blood coagulation disease for the clarification of a bleeding disorder or thrombophilia usually vary between 1.200 and 2.000 Euros. The amount of charge is not bound to the usage of different factors of private liquidation, but specific examination methods. Billing is based on the scale of charges for physicians (GOÄ) at the usual rate of increase. Therefore, costs can vary between individual questions, especially when genetic examinations are required. The preparation of cost estimates is possible.

Dependent on the clinical question a suitable examination might need to be performed in an external laboratory. In this case, you will receive a separate bill from the external laboratory.

With your signature you agree with this procedure of settlement and the cession of medical fees to ABV for all following medial treatments by us until revocation.

Additionally, you comply with taking over costs from external laboratories.

I agree with the procedure of settlement.
I am informed about my right of written revocation at any time for future administration according to art. 7 GDPR.
I received a copy of this form

Place, date

X

signature patient/statutory representative

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