Patient information

CBT
Centrum für Blutgerinnungsstörungen und Transfusionsmedizin

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).

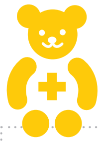
Please bring your OAC (e.g. Xarelto® and Eliquis®) to your appointment, so you may take it after blood collection as usual.

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-Version 2.7 (11/2021)-F034_e

Centrum für Blutgerinnungsstörungen und Transfusionsmedizin



Admission and Medical History

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

Mobil

E-Mail

Health Insurance

Patients with private insurance

Last Name, First Name

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

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

Blood type ....

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

Transferring Physician

Name

Street

City

Fax

Referring Physician

Name

Street

City

Fax

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

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

004-Version 5.0 (09/2018)-F033_k_en

© 2019 - CBT Centrum für Blutgerinnungsstörungen und Transfusionsmedizin®

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

© 2018 - CBT Centrum für Blutgerinnungsstörungen und Transfusionsmedizin®

PatID

I. Current and known diseases

1. Does your child currently have bronchitis or a feverish cold? ☐ Yes ☐ No

2. Does your child currently have an infection? ☐ Yes ☐ No

   What type of infection? ....

3. Does your child have an allergy? ☐ Yes ☐ No

   Please list all known allergies:

   ....

   ....

4. Does your child have diabetes? ☐ Yes ☐ No

5. Does your child have a liver desease (e.g. hepatitis)? ☐ Yes ☐ No

   What type of liver disease? ....

5. Does your child have a kidney desease? ☐ Yes ☐ No

   What type of kidney disease? ....

6. Does your child has a heart desease? ☐ Yes ☐ No

   What type of heart desease? ....

7. Has your child been diagnosed with an autoimmune disease? ☐ Yes ☐ No

   What disease? ....

8. Does or did your child have any other disease or medical condition? Please list or describe:

II. Medications

1. Has your child taken pain medication in the last 10 days? ☐ Yes ☐ No

   If yes, which one? ....

2. Does your child take any other medication regularly? ☐ Yes ☐ No

   Please list the medication and dosage:

Medication	Dosage

004-Version 5.0 (09/2018)-F033_k_en

© 2018 - CBT Centrum für Blutgerinnungsstörungen und Transfusionsmedizin®

III. Thrombosis and Embolism

1. Does your child currently have or has it recently had a thrombosis ? ☐ Yes ☐ No

   If not applicable continue to the next section.

2. When did your child have a thrombosis? .... /......... (month / year)

3. Check the appropriate box that best describes your child´s thrombosis.
   - ☐ Superficial thrombosis (phlebitis)
   - ☐ Muscular vein thrombosis
   - ☐ Deep vein thrombosis
   - ☐ Portal vein thrombosis
   - ☐ Pulmonary embolism
   - ☐ I don´t know.

4. Which area of body was affected?
   - ☐ Lower leg
   - ☐ Thigh
   - ☐ Pelvic veins
   - ☐ Arm vein
   - ☐ Clavicular vein
   - ☐ Sinus veins (head)
   - ☐ Lungs
   - ☐ Other: ....
   - ☐ Left side of the body
   - ☐ Right side of the body

5. How was the thrombosis diagnosed?
   - ☐ Through an ultrasound scan
   - ☐ Through a contrast medium examination (x-ray)

   If it was a lung embolism, how was it diagnosed?
   - ☐ Through a nuclear medicine exam
   - ☐ Through computer tomography (CT)

6. Before your child´s thrombosis, did he or she have to stay lying for a long time? ☐ Yes ☐ No

   If yes, why?

☐ Hospital stay	How long: ....
☐ Surgery	How long: ....
☐ Plaster cast on the leg or foot	How long: ....
☐ Injury:	How long: ....
☐ Other:	How long: ....

7. Did your child have an infection or fever in the weeks before the thrombosis? ☐ Yes ☐ No

8. Did your child have a tumor when the thrombosis occured? ☐ Yes ☐ No

   What type of tumor? ....

IV. Tendency to bleed

1. Does your child bleed often? ☐ Yes ☐ No

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

   ....

   ....

   ....

2. When your child has an incised wound or an abrasion is it dfficult to stop the bleeing? ☐ Yes ☐ No

3. Does your child have problems with healing of wounds? ☐ Yes ☐ No

4. Do you notice bleeding gums when your child is brushing teeth? ☐ Yes ☐ No

   If yes ☐ when brushing teeth ☐ without any apparent reason

© 2018 - CBT Centrum für Blutgerinnungsstörungen und Transfusionsmedizin®

5. Does your child bruise easily from minor interactions? ☐ Yes ☐ No

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

6. Does your child has frequent nose bleeds? ☐ Yes ☐ No
   If **yes**

a) How often?
☐ 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) Does your child have nose bleeding without any apparent reason? ☐ Yes ☐ No

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

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

What treatment was performed to eliminate the nose bleeds (e.g. cauterization)?

....

7. Did you ever notice blood in your child´s urine or stools? ☐ Yes ☐ No

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

8. Has your child ever been diagnosed with „blood clotting disorder" (e.g. hemophilia)? ☐ Yes ☐ No

If yes, what disorder? ....

9. Has your child 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 your child receive a blood transfusion due to excessive bleeding?
d) When (month/year) was the operation?

Surgical Procedure	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	...... / ....

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

What type of procedure? ....

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

004-Version 5.0 (09/2018)-F033_k_en

© 2018 - CBT Centrum für Blutgerinnungsstörungen und Transfusionsmedizin®

V. Family Anamnesis

Inherited blood coagulation disorder

1. How many siblings does your child have? (also half-siblings) ....

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

2. Is someone in your child´s 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	☐	☐	☐

3. 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!

004-Version 5.0 (09/2018)-F033_k_en

© 2018 - CBT Centrum für Blutgerinnungsstörungen und Transfusionsmedizin®

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 ....

CBT
Centrum für Blutgerinnungsstörungen und Transfusionsmedizin

Stamp

G 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.

....

Place, date | Signature patient/ legal representative

....

Signature physician

004-Version 5.2 (06/2019)-F013_en

© 2019 - CBT Centrum für Blutgerinnungsstörungen und Transfusionsmedizin®

Notice of patient information

CBT
Centrum für
Blutgerinnungsstörungen
und Transfusionsmedizin

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 be forwarded to you and with your consent to you general practicioner/medical specialist by post. The final report needs about 4 weeks – with special genetic examinations even longer. If you or your general practicioner/medical specialisit require the test results earlier, you can always request them from us.

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. Referring Doctor:

name

2. General practicioner:

name

3. Relatives:

last name	first name	date of birth
last name	first name	date of birth
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

© 2020 - CBT Centrum für Blutgerinnungsstörungen und Transfusionsmedizin | Am Propsthof 3 | 53121 Bonn www.cbtmed.de | info@cbtmed.de

Notice of patient information

Centrum für Blutgerinnungsstörungen und Transfusionsmedizin

Data privacy statement

I took note of the data privacy statement with cross reference to the advice and complaint form of individual data, which can be found in the waiting area and on our homepage **www.cbtmed.de**.

last name

first name

date of birth

street address

city

city, date

signature patient/statutory representative

Consent to appointment reminders via SMS and / 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.

☐ I would like to receive an appointment reminder.

Mobile phone number: ______

E-Mail: ______

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

signature patient/statutory representative

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

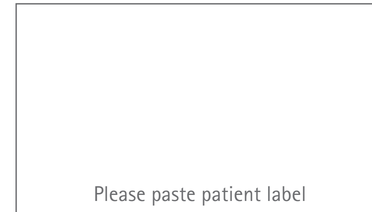
I have received a copy of this form.

signature patient/statutory representative

© 2020 - CBT Centrum für Blutgerinnungsstörungen und Transfusionsmedizin | Am Propsthof 3 | 53121 Bonn

www.cbtmed.de | info@cbtmed.de

Additionally for PRIVATE INSURED



Transfer of personal data
Consent form

Please paste patient label

Dear patient,

Subsequently to your examinations and if applicable your treatments at 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 1.400 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

signature patient/statutory representative

© 2020 - CBT Centrum für Blutgerinnungsstörungen und Transfusionsmedizin®

www.cbtmed.de | info@cbtmed.de