



# 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	

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

Patients with private insurance
Last Name, First Name
Address (Please provide Insurance Policy owner, if different than address above.)

Transferring Physician
Name
Street
City
Fax

Height .....	Weight .....	BMI .....
Blood type .....		

Referring Physician
Name
Street
City
Fax

RR: .....	Pulse rate: .....
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Blood: Date/time .....	Implemented by (abbreviation): .....
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Continuation of Medical History (to be filled out by the doctor)

Large grid area for writing medical history.



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 disease (e.g. hepatitis)?  Yes  No

What type of liver disease? .....

5. Does your child have a kidney disease?  Yes  No

What type of kidney disease? .....

6. Does your child has a heart disease?  Yes  No

What type of heart disease? .....

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



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  Clavicular vein  Left side of the body
 Thigh  Sinus veins (head)  Right side of the body
 Pelvic veins  Lungs
 Arm vein  Other: .....

- 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 occurred?  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 difficult to stop the bleeding?  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



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?

Table with 5 columns: Surgical Procedure, a) bleeding within the first few hours, b) bleeding within the first days, c) Transfusion required, d) When? (month/year). It contains 5 empty rows for data entry.

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

What type of procedure? .....

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



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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	..... years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	..... years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	..... years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	..... years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>

Thank you very much for answering the questions!

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:		
<input type="checkbox"/> male	<input type="checkbox"/> female	<input type="checkbox"/> undefined
Ethnical origin .....		

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







## 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](http://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.

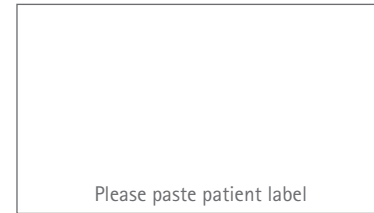
I have received a copy of this form.



signature patient/statutory representative

▶ **Additionally for PRIVATE INSURED**

## Transfer of personal data Consent form



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