|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT REGISTRATION FORM**  Clinician/Nurse to complete. **Fields marked with an \*asterisk are mandatory**, optional fields are shaded grey. | | | | | | | | | | | | | | | | | | | | | | | |
| **🞎 New patient** | | | |  | **🞎 Change of name** | | | | |  | **🞎 Change of address** | | | | | | | | |  |  |  | |
| **Patient** | | | | | | | | | | | | | | | | | | | | | | | |
| **ABDR ID** (Existing patients only) | | | |  | **Title** | | | | |  | **Australian Resident Status** (Please tick)  **🞎** Australian Citizen/Permanent Resident **🞎** Overseas Visitor  **🞎** Temporary Visa | | | | | | | | | | | | |
|  | | |  |  |  | |  | | |  |
| **\*First name** | | | |  |  | | | | **Second name / Initial** | | | | | | |  |  | **\*Family name** | | | | | |
|  | | |  |  |  | |  | |  | |  | | | | |  |  |  | | | |  | |
| **Known as / Alias** | | | |  | **\*Gender** | |  | | |  | **\*Date of birth** | | | | | | | | |  | **Previous family name/s** | | |
|  | | |  |  | **🞎** Male  **🞎** Female | | | | |  | **/ /** | | | | | | | | |  |  |  | |
| **\*Address** | | |  |  |  | |  | | |  |  | | |  | | | | | |  |  |  | |
| **1** |  | | |  |  | |  | | |  |  | | | **\*Suburb** | | | | | |  |  |  | |
| **2** |  | | |  |  | |  | | |  |  | | | **\*State** | | | | | |  |  |  | |
| **3** |  | | |  |  | |  | | |  |  | | | **\*Postcode** | | | | | |  |  |  | |
|  | | |  |  |  | |  | | |  |  | | | **Country** | | | | | |  |  |  | |
| **🞎 Home phone** | | | |  | **🞎 Work phone** | | | | |  | **🞎 Mobile** | | |  | | | | | |  |  |  | |
|  | | |  |  |  | |  | | |  |  | | |  | | | | | |  | **\***Tick preferred contact method; at least one contact must be supplied. | | |
| **🞎 Home email** | | | |  |  | |  | | |  | **🞎 Work email** | | | | | | | | |  |
|  | | |  |  |  | |  | | |  |  | | |  | | | | | |  |  |  | |
|  | | | |  |  | |  | | |  |  | | |  | | | | | |  |  |  | |
| **Patient contact** (mandatory if patient is under 18) | | | | | | | | | | | | | | | | | | | | | | | |
| **🞎 Mother 🞎 Father 🞎 Spouse 🞎 Grandparent 🞎 Emergency 🞎 Other**  Please specify: | | | | | | | | | | | | | | | | | | | | | | | |
| **Title** | | |  |  | **First name** | |  | | |  | **Second name / Initial** | | | | | | | | |  | **Last name** | | |
|  | | |  |  |  | |  | | |  |  | | |  | | | | | |  |  |  | |
| **Address** | | |  |  |  | |  | | |  |  | | |  | | | | | |  |  |  | |
| **1** |  | | |  |  | |  | | |  |  | | | **Suburb** | | | | | |  |  |  | |
| **2** |  | | |  |  | |  | | |  |  | | | **State** | | | | | |  |  |  | |
| **3** |  | | |  |  | |  | | |  |  | | | **Postcode** | | | | | |  |  |  | |
|  | | |  |  |  | |  | | |  |  | | | **Country** | | | | | |  |  |  | |
| **🞎 Home phone 🞎 Work phone 🞎 Mobile 🞎 Home email 🞎 Work email**  Tick best contact method | | | | | | | | | | | | | | | | | | | | | | | |
| **Best contact number or email address** | | | | | | | | | |  |  | | | | | | | | |  |  |  | |
|  | | | |  |  | |  | | |  |  | | | | | | | | |  |  |  | |
| **Diagnosis**  See overleaf for # options | | | | | | | | | | | | | | | | | | | | | | | |
| **\* Date diagnosed** | | | |  | **\*Bleeding disorder #** | | | | | |  | | | | | | | | |  |  | | |
| **/ /** | | | |  |  | |  | | |  |  | | |  | | | | | |  |  |  | |
| **\*Severity** | | |  |  | **Baseline factor date** | | | | | | **Baseline factor level** | | | | | | | | |  | **\*Weight in kilograms** | | |
|  | | |  |  | / / | | | | |  |  | | | % | | | | | |  |  |  | |
| Mild / Moderate / Severe / Unknown / Not applicable | | | |  | (Where applicable) | | | | |  | (Where applicable) | | | | | | | | |  |  |  | |
| **Treatment** See overleaf for + ^ options | | | | | | | | | | | | | | | | | | | | | | | |
| **\*Regimen +** | | | |  | **\*Product name ∧** | | | | |  | **\*Total dose** | | | | | | | | |  | **\*Frequency** | | |
|  | | |  |  |  | |  | | |  |  | | |  | | | | | |  |  |  | |
| **Comments** | | | |  |  | |  | | |  |  | | |  | | | | | |  |  |  | |
|  | | |  |  |  | |  | | |  |  | | |  | | | | | |  |  |  | |
|  | | |  |  |  | |  | | |  |  | | |  | | | | | |  |  |  | |
| **Attending Physician and Clinic / Hospital Address** Missing data will be requested by an ABDR Data Manager. | | | | | | | | | | | | | | | | | | | | | | | |
| **\*Title** | | |  |  | **\*First name** | | | | |  |  | | | **\*Last name** | | | | | | | |  | |
|  | | |  |  |  | |  | | |  | | |  |  | | | | | |  |  |  | |
| **\*Name of Clinic / Hospital** | | | | | | |  | | |  | **\*Best contact number or email address** | | | | | | | | | | | | |
|  | | |  |  |  | |  | | |  |  |  | | | | | | |  | |  |  | |
| **\*Address** | | |  |  |  | |  | | |  |  |  | | | | | | |  | |  |  | |
| **1** |  | | |  |  | |  | | |  |  | **\*Suburb** | | | | | | |  | |  |  | |
| **2** |  | | |  |  | |  | | |  |  | **\*State** | | | | | | |  | |  |  | |
| **3** |  | | |  |  | |  | | |  |  | **\*Postcode** | | | | | | |  | |  |  | |
|  | | |  |  |  | |  | | |  |  |  | | | | | | |  | |  |  | |
| **DECLARATION:** | | | |  |  | |  | | |  |  |  | | | | | | |  | |  |  | |
| These details are true and correct at the time of completing this form. I have read the *ABDR User* *Terms and Conditions* and the *ABDR Privacy Consent Policy* and I understand my role and obligations in populating the ABDR. The patient is also aware of the purpose for capturing their details in the ABDR and has been provided with a copy of the ABDR Patient Information and Informed Consent Pamphlet and the ABDR/MyABDR Privacy Collection Notice. I have confirmed the patient’s understanding of those materials and obtained the patient’s express consent for the collection of their personal information in the ABDR. | | | | | | | | | | | | | | | | | | | | | | | |
| **Name** | |  | |  |  | | | **Signature** | | |  | | |  | | | | | |  | **Date** | **/ /** | |
| **#Bleeding Disorder**  Factor II deficiency (Prothrombin)  Factor V deficiency  Factor VII deficiency  Factor VIII deficiency (Haemophilia A)  Factor IX deficiency (Haemophilia B)  Factor X deficiency  Factor XI deficiency  Factor XII deficiency  Factor XIII deficiency  Symptomatic Carrier Factor VIII deficiency (Haemophilia A)  Symptomatic Carrier Factor IX deficiency (Haemophilia B)  Asymptomatic Carrier Factor VIII deficiency (Haemophilia A)  Asymptomatic Carrier Factor IX deficiency (Haemophilia B)  von Willebrand Disease Type 1  von Willebrand Disease Type 2 – Uncharacterised  von Willebrand Disease Type 2A  von Willebrand Disease Type 2B  von Willebrand Disease Type 2M  von Willebrand Disease Type 2N  von Willebrand Disease Type 3  von Willebrand Disease – Uncharacterised  Fibrinogen – Afibrinogenemia  Fibrinogen – Hypofibrinogenemia  Fibrinogen – Dysfibrinogenemia  Fibrinogen dysfunction – Uncharacterised  Platelet – Glanzmann’s thrombasthenia  Platelet – Bernard-Soulier  Platelet – May Hegglin  Platelet – Macrothrombocytopenias  Platelet – Storage pool (dense granule) deficiency  Platelet – Primary secretion defect  Platelet – Uncharacterised  Acquired factor VIII inhibitor (Acquired Haemophilia A)  Acquired von Willebrand’s Disease  Vascular disorders – Ehlers Danlos Syndrome  Vascular disorders – Uncharacterised  Other, please specify | | | | | | **+Treatment Regimen**  On demand  Prophylaxis  Tolerisation  Secondary Prophylaxis | | | | | | | | | **∧Product Name (Type)**  Advate® (rFVIII)  BeneFIX® (rFIX)  Biostate® (pdFVIII)  Ceprotin® (Protein C)  Cryoprecipitate  DDAVP (Synthetic hormone)  Factor Eight Inhibitor Bypass Agent (FEIBA®) (Bypassing Agent)  Factor VII Concentrate® (pdFVII)  Factor XI bpl® (pdFXI)  Factor XI LFB Hemoleven® (pdFXI)  Fibrogammin P® (pdFXIII)  Fresh Frozen Plasma (FFP)  Haemocomplettan P 1g (pdFXIII)  Intravenous Immunoglobulin (IVIg)  Kogenate (rFVIII)  Kogenate FS – Blood Service (rFVIII)  MonoFIX® - VF (pdFIX)  NovoSeven® (rFVIIa)  NovoSeven RT® (rFVIIa)  Platelets  Prothrombinex™ - VF (pdPCC)  Recombinate® (rFVIII)  ReFacto® (rFVIII)  Xyntha (rFVIII)  Xyntha Dual Chamber (rFVIII) | | | | | | | |