INDIAN ASSOCIATION FOR HAEMOPHILIA AND ALLIED DISORDERS

HAEMOPHILIA TREATMENT CENTER REGISTRATION FORM

Please note:

1. This is an editable PDF. Please fill this and share back to IAHAD at pm@iahad.org
2. You can also print, fill and scan a copy back to us at pm@iahad.org
3. Kindly note that only ONE registration will be accepted per HTC. Please discuss with your team before sharing the final version.

Name of the HTC: _____
Address: _____
State: _____
Email ID of the HTC: _____ **Phone No: _____**
Name of the Director/HTC In-Charge: _____
Email ID: _____ **Phone No: _____**

1. Total number of patients with a Hereditary Bleeding Disorder registered at the centre: _____
2. Total number of patients with a Hereditary Bleeding Disorder on regular annual follow up: _____

Bleeding Disorder	Patients Registered	Patients with Annual Follow-Up	Patients with Severe Disease
Haemophilia A			
Haemophilia B			
VWD Type 1			
VWD Type 2			
VWD Type 3			
VWD Type Unknown			
Afibrinogenemia (<10mg/dl)			
Hypofibrinogenemia (50-150mg/dl)			
Dysfibrinogenemia (10-50mg/dl)			
Factor II Deficiency			
Factor V Deficiency			
Factor VII Deficiency			
Factor X Deficiency			
Factor XI Deficiency			
Factor XIII Deficiency			
Combined Factor V + VIII Deficiency			
Combined Factor II + VII + IX + X Deficiency			
Glanzmann’s thrombasthenia			
Bernard Soulier Syndrome			
Others			

Haemophilia Treatment Center - Comprehensive Team members details.
(Members can be added every year. Member List to be updated every year)

MEMBERS	Name (Full name with initials)	E-mail address
Physician		
Pathologist		
Nurse Coordinator		
Physiotherapist		
Orthopaedic Surgeon		
Other Surgeons		
Laboratory Scientists		
Data Manager		
Psycho-Social Team		
Coordinator		
Other		

**** Each Category can have multiple names. ***Leave it blank if not available**

Consent: I agree to register our HTC as an Institutional Member of IAHAD.
I hereby declare that the entries made in this form as above is true and correct to the best of my knowledge and belief.

Signature - Head / Physician In-charge of HTC

Name:	Signature:	Date: