**APPLICATION FORM**

**FOR EUROPEAN HAEMOPHILIA CENTRE CERTIFICATION**

**Please submit the completed form to info@eahad.org**

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| **SECTION 1 – CONTACT DETAILS** |

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| 1.1  |
| Country |  |
| City |  |

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| 1.2 |
| Centre name in English |  |
| Centre name in own language |  |
| Centre address |  |
| Telephone |  |
| Fax |  |
| Email |  |
| Centre website (if available) |  |

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| 1.3 |
| Hospital/Institute name |  |
| Centre address |  |
| Telephone |  |
| Hospital/Institution website (if available) |  |

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| 1.4 Centre Director  |
| Title |  |
| Name |  |
| Address if different to Haemophilia centre address: |  |
| Telephone |  |
| Fax |  |
| Email |  |

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| 1.5  |
| Are you based in more than one hospital/location?If yes, please provide details: |

Please describe your service. The assessors of this application will not know your centre, so please describe your centre, what you do and what you offer.

Please limit your description to 250 words and note that your description will be made publicly available.

(You are free to describe your centre in any way you wish but examples of areas to be included are: location, number of staff, diversity of staff, total number of patients, available facilities, experiences with surgery, collaborations with other centres, out of hours arrangements for care etc.)

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| 1.6 |
| Name of person completing this application |  |
| Position of person completing this application |  |
| Email of person completing this application |  |

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| 1.7 Description Of Centre |

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| **SECTION 2 – CERTIFICATION GOAL** |

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| 2.1 |
| *Which of the following would you like to be considered for: Select one only and write in relevant box* | Yes/No |
| European Haemophilia Treatment Centre (EHTC) |  |
| European Haemophilia Comprehensive Care Centre (EHCCC) |  |
| Both (The panel will allocate the most appropriate category based on the data you supply)  |  |

If you have any comments please add them below.

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| **SECTION 3 – PATIENTS TREATED BY YOUR CENTRE** |

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| 3.1 |
| *Age groups treated by your centre: Select one only and write in the relevant box* | Yes/No |
| Adult patients only |  |
| Paediatric (children) patients only |  |
| Both adults and paediatric patients |  |

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| 3.2 |
| Total number of patients with congenital bleeding disorders under follow-up by your centre (all severities) |  |

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| 3.3 |
| In the following table please indicate the number of **severe** patients in follow-up by your centre: |
|  | **Paediatric (ie Children)** | **Adults** |
| Severe haemophilia A (<1% FVIII) |  |  |
| Severe haemophilia B (<1% FIX) |  |  |
| Type 3 von Wiliebrand disease |  |  |
| Total of above 3 rows |  |  |

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| 3.4 |
| In the following table please give the number of patients with each disorder under follow-up at your centre. Severe is defined as <10% clotting factor level. For this table please combine the adults and children under follow-up. |
| **Disorder** | **Number of patients** | **Severe (<10% factor level)** |
| Afibrinogenemia |  | Not applicable |
| Other fibrinogen disorders |  | Not applicable |
| Factor II deficiency |  |  |
| Factor V deficiency |  |  |
| Factor VII deficiency |  |  |
| Factor X deficiency |  |  |
| Factor XI deficiency |  |  |
| Factor XIII deficiency |  |  |
| Bernard Soulier Syndrome |  | Not applicable |
| Glanzmann Thrombasthenia |  | Not applicable |

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| 3.5 |
| Do you perform Immune Tolerate induction (ITI) at your centre? | Yes/No\*\* |

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| 3.6 |
| Please indicate the number of patients with Congenital Haemophilia A or B with inhibitors at your centre. |
|  | **Number of patients** |
| Patients with current inhibitors not on ITI |  |
| Patients currently on ITI |  |
| Patients with previous inhibitors |  |

Please give any comments you have regarding the number of patients under follow-up.

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| **SECTION 4 – KEY PERSONNEL** |

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| 4.1 Specialty of centre director:Eg haematologist, paediatrician, internal medicine doctor |  |

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| 4.1.2 Name of centre co-director(s) (if applicable): |  |

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| 4.1.3 Name of other Haemophilia Specialist Medical staff |
| Name | Speciality | Position | Full time in haemophilia care (Yes or No) |
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| 4.1.4 Haemophilia nurse(s) |
| Name | Speciality | Position | Full time in haemophilia care (Yes or No) |
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| 4.2 |
| How many whole-time equivalent nurses dedicated to Haemophilia care do you have? |  |

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| 4.3 Haemophilia physiotherapist |
| Name | Speciality | Position | Full time in haemophilia care (Yes or No) | Is this person full time for Haemophilia care |
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| Section for other specified staff  |

Please give the names of any other staff who have provided full or part time care to Haemophilia patients. E.g. Study coordinator, psychologist, social worker, etc.

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| 4.4 |
| Name | Speciality | Position | Full time in haemophilia care (Yes or No) |
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| Comments |

Please provide any comments relating to personnel at your centre that you wish the assessors to see.

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| **SECTION 5– EMERGENCIES, TREATMENT OUTSIDE NORMAL WORKING HOURS** |

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| 5.1 |

Explain your plan for 24 hour emergency care for your patients. Please also indicate if this is provided at your own hospital or in another centre.

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| 5.2 |
| Are patients informed by your centre whom they should contact in the event of an emergency or in case treatment is needed outside normal working hours? | Yes/No\*\* |

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| 5.2.1 |
| Does the centre provide 24 hour expert Haemophilia medical cover? (ie can patients be seen and if required admitted on a 24 hour basis and the opinion of a senior haemophilia expert be obtained) | Yes/No\*\* |

If Yes to question 5.2.1 Please list the names of Haemophilia Medical Specialists on the on call rota. This list will be made publically available on your centre’s entry.

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If you have any comments please add them below:

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| **SECTION 6 – ENTRY FOR HAEMOPHILIA CENTRE LOCATOR** |

The website [www.hclocator.org](http://www.hclocator.org) is freely available. A patient with a bleeding disorder and internet or mobile phone access can easily find the nearest haemophilia centre. This is intended for travelling patients to get emergency care. All Haemophilia centres in Europe should already be on the system. Please check the entry and location for your centre.

Please note the information on this section will be made publically available.

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| 6.1 |
| Is your centre listed on the haemophilia centre locator (www.hclocator.org)? | Yes/No\*\* |

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| 6.2 |
| The telephone number given at hclocator.org for my centre is correct? | Yes/No\*\* |
| Comments: |

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| 6.3 |
| The email address given at hclocator.org for my centre is correct? | Yes/No\*\* |
| Comments: |

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| 6.4 |
| The map given at hclocator.org for my centre is correct? | Yes/No\*\* |
| Comments: |

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| 6.5 |
| Does your centre treat children only? | Yes/No\*\* |
| If you have answered yes please give the age up to which you will see patients. |
| 6.6 |
| Does your centre treat adults only? | Yes/No\*\* |

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| 6.7 |
| Does your centre treat children and adults? | Yes/No\*\* |

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| Advice to patients who require emergency care |

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| 6.8 |
| During normal working hours: (please give contact phone number, what hours and what days are normal working hours and location where should patients go to access emergency haemophilia care.) |

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| 6.9 |
| Outside normal working hours: (please give contact phone number and location of centre where patients should go for emergency haemophilia care.) |

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| Clotting factor concentrate availability |

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| 6.10 Please indicate which clotting factor concentrates you have quick access to and indicate if these products are available during normal working hours only or on a 24-hour basis. |
| **Concentrate** | **Availability during normal working hours only** | **Available on a 24-hour basis** |
| FVII |  |  |
| FVIII |  |  |
| FIX |  |  |
| FX |  |  |
| Von Wilebrand factor containing concentrate |  |  |
| Bypassing agentsIe Novoseven or FEIBA |  |  |
| FXI |  |  |
| FXIII |  |  |
| Fibrinogen |  |  |

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| **SECTION 7 – LABORATORY REQUIREMENTS** |

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| **Tests** |  |
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| **1. PT, APTT, Thrombin time and mixing studies** | Yes/No\*\* | TAT\*: within 3 hours | Yes/No\*\* | 24 hr service | Yes/No\*\* |
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| Comments: |
| **2. Factor VIII and IX assays** | Yes/No\*\* | TAT\*: within 6 hours | Yes/No\*\* | 24 hr service | Yes/No\*\* |
|  |  |  |
| Comments: |
| **3. Inhibitor screen \*\*** | Yes/No\*\* | TAT\*: within 12 hours | Yes/No\*\* | 24 hr service | Yes/No\*\* |
|  |  |  |
| Comments: |
| **4. Fibrinogen, von Willebrand factor and factors V, VII, X, XI and XIII assays**  | Yes/No\*\* | TAT\*: within 12 hours | Yes/No\*\* | 24 hr service | Yes/No\*\* |
|  |  |  |
| Comments: |
| **5.Platelet aggregation** | Yes/No\*\* |  |
| Comments: |
| **6. VWF multimers** | Yes/No\*\* |  |
| Comments: |

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| 7.1 Which of the following tests are performed by your centre (via access to a laboratory, either internally or externally)? |

\* TAT (turnaround time: completion time from sample collection to result reporting)
\*\* by inhibitor screen it is accepted that this could be an APTT mixing study and measurement of FVIII:C

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| 7.2 Other tests available at your centre: |
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| 7.3 |
| Are molecular genetic tests for Haemophilia A and B offered by your centre? | Yes/No\*\* |
| 7.3.1 If you have answered yes please indicate whether they are performed at your hospital or are they sent to another centre? |

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| 7.4 |
| Is the Turnaround Time for laboratory tests agreed in writing between the clinical and laboratory services and is it subject to monitoring? | Yes/No\*\* |
| If you have any comments please add them below. |

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| 7.5 |
| Do the laboratories that perform the above-mentioned tests participate in an accredited external quality assurance scheme in Haemostasis e.g. ECAT, NEQAS? | Yes/No\*\* |
| 7.5.1 If yes, which external quality assessment schemes that provide Haemostasis tests do you participate in? |

Comment box – Please provide any information you may wish regarding your laboratory provisions.

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| **SECTION 8 – NETWORK OF CLINICAL AND SPECIALISED SERVICES IN CONJUNCTION WITH THE HAEMOPHILIA TEAM** |

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| 8.1 |
| Has your centre established an active relationship with one or more Haemophilia Comprehensive Care Centres? | Yes/No\*\* |
| 8.1 If yes, please name the centres |

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| 8.2 Please indicate the support available in your centre in the list of following specialties by placing an X in the relevant column |
|  | **Yes: in-house**  | **No: referred elsewhere** | **No** |
| Physiotherapy |  |  |  |
| Orthopaedic Surgery |  |  |  |
| General Surgery |  |  |  |
| Dental care |  |  |  |
| Paediatrics |  |  |  |
| Hepatology, Infectious diseases |  |  |  |
| Obstetrics and Gynaecology |  |  |  |
| Genetics counselling |  |  |  |
| Psycho-social support, particularly regarding provision of social welfare, occupational therapy and counselling services |  |  |  |

If you have any comments please add them below.

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| **SECTION 9 – ADVERSE EVENT REPORTING** |

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| 9.1 |
| Do you formally report adverse events such as new inhibitors or thrombosis related to concentrates to anybody e.g. EUHASS, Nation Registry etc? | Yes/No\*\* |
| 9.1.1 If you have answered yes please give the bodies to which you report your adverse advents. |

Comments: Please add any comments about adverse event reporting at your centre

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| **SECTION 10 – PUBLICATIONS AND RESEARCH**  |

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| Publications |

10.1 Please list the publications from your centre (these could be collaborative) in the last 5 years. Please provide the full reference i.e. authors, title, journal, year, volumes and pages. Please indicate in bold the authors working at your centre when the work was carried out.

If the number exceeds 10 and you do not wish to list them all please give the top 10 that demonstrates the comprehensive care offered by your centre

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| Research |

10.2 Please give a list of the research projects (dealing with congenital bleeding disorders) currently being undertaken at your centre. Commercial/industry studies are acceptable for inclusion here:

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| **SECTION 11– ADDITIONAL INFORMATION** |

11.1 Please provide any additional information you think may be helpful about your centre

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| **SECTION 12– AVAILABILITY OF INFORMATION FROM THIS FORM TO THE PUBLIC** |

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| 12.1 |
| Are you happy for the indicated sections to be made publicly available? | Yes/No\*\* |
| 12.1.1 If you have answered no please indicate the sections you wish to remain confidential and explain the reasons why. It is expected that only in exceptional circumstances will this information not be made public. The reasons behind the request will need to be explained to the panel. |

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| **To be completed by the person responsible for application for certification** |
| I hereby authorise the disclosure of all non-confidential information provided in this application on the EUHANET website  |
| **Name** |  |
| **Position** |  |

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| **Date** |  | **Signature** |  |

**Please submit the completed form to** [**info@eahad.org**](file:///C%3A%5CUsers%5Cangel%5CDownloads%5Cinfo%40eahad.org)