

Identification Number:

**International Registry for Levonorgestrel Intrauterine System
In Women with Inherited Bleeding Disorders**

Please return this form to:

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Treatment Centre.....	Identification Number.....
City.....	
Country.....	
Name of Doctor/Provider.....	

Patient details:

Initials..... Date of Birth.....
Date / Month / Year

Bleeding disorder:

Haemophilia A carrier	<input type="checkbox"/>	Fibrinogen deficiency	<input type="checkbox"/>
Haemophilia B carrier	<input type="checkbox"/>	Prothrombin deficiency	<input type="checkbox"/>
Von Willebrand's Disease	<input type="checkbox"/>	Factor V deficiency	<input type="checkbox"/>
Factor VII deficiency	<input type="checkbox"/>	Factor V and VIII deficiency	<input type="checkbox"/>
Factor IX deficiency	<input type="checkbox"/>	FXIII deficiency	<input type="checkbox"/>
Factor X deficiency	<input type="checkbox"/>	Others (please state)	<input type="checkbox"/>
		

Severity:

Severe Moderate Mild

Relevant factor levels:

Coagulant activity of missed factor(s) (IU/dL)

.....

Antigen level of missed factor(s) (IU/dL)

.....

Age at Diagnosis:years

Levonorgestrel Intrauterine System

Accept **Decline** (Reason.....)

1. Date of insertion (Date / Month / Year)

2. Indication: Contraception
Menorrhagia
Others (please specify)
.....

3. Haemostatic cover: No
Yes please state.....

4. Anaesthesia: None
Local
General

5. Complication during insertion: Bleeding
Uterine Perforation
Pain
Pain scale of 1(mild) - 10(severe).....

6. At time of insertion: Haemaglobin (g/dL)
Haematocrit
Ferritin

7. Pelvic Ultrasound: Normal
Abnormal (Please describe.....
.....
.....
.....)

8. Menstrual Cycle: Regular Irregular

Length of each cycle.....days

Length of each period.....days

Blood clots: Yes No

If yes please specify the approximate size of the blood clots:

(you may tick more than one)

The size of a one pence coin (1/2 inch) or smaller

The size of a 10 pence coin

The size of a 50 pence coin (1 inch) or bigger

Flooding: Yes No

PBAC score if available

(PBAC – Pictorial Blood Assessment Chart)

Time lost from school and/or work due to periods in the last year:days

9. Previous treatment for heavy menstrual loss:

	Effective	Slightly Effective	Not Effective
Tranexamic Acid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COCP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cyclical Progesterone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DDAVP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other: (Please specify).....

Reason for discontinuation of previous treatment(s):

.....
.....
.....

Concomitant use of any of the above: No

Yes please state.....

10. Quality of Life Baseline:

On scale of 0 (no effect) to 10 (most effect), how much does the period interfere with the following: (Please circle the appropriate number for each statement)

General Activity	1	2	3	4	5	6	7	8	9	10
Ability to work or go to school	1	2	3	4	5	6	7	8	9	10
Normal family activities	1	2	3	4	5	6	7	8	9	10
Sleep	1	2	3	4	5	6	7	8	9	10
Ability to enjoy life	1	2	3	4	5	6	7	8	9	10
Mood	1	2	3	4	5	6	7	8	9	10

Follow-up at 1 Month

1. Irregular bleeding/Spotting: No Yes

If yes, for how many days does it occur?days

Is it continuous? No Yes

2. Menstruation since insertion: No Yes

If Yes, please specify the duration of your period and a PBAC score if available:

Duration of period:..... PBAC score:.....

3. Thread visualised: No Yes

4. Expulsion: No Yes

5. Removal: No Yes

- Reason for removal:
- Irregular bleeding/spotting
 - Hormonal side effect
 - Persistent menorrhagia
 - Others (please specify)

