



17092

Bosentan Patient Registry Data Form

Please complete on all visits

Please print in CAPITALS and fill in circle, do NOT tick

Office Use Only

BPR ID

1. Patient Information (Required)

Title _____ First Name _____ Initial Last Name _____

DOB (dd/mm/yyyy) _____ Sex: Male Female # _____

Medicare No. _____

2. Patient Contact Details (Complete when enrolling or if changed since last prescription)

Address _____

Suburb _____ Postcode _____ State _____

Phone (_____) _____ - _____ Mobile Phone _____

3. Alternate Contact Details (Complete when enrolling or if changed since last prescription)

First Name _____ Last Name _____

Address _____

Suburb _____ Postcode _____ State _____

Phone (_____) _____ - _____ Mobile Phone _____

4. Prescriber Information (Required)

First Name _____ Last Name _____

Prescriber No. (_____) _____ - _____ Phone (_____) _____ - _____ Fax

Script No. _____ Prescribers Signature _____ Todays date (dd/mm/yyyy) _____

5. Additional Registry Information (Required)

Date patient first started bosentan (this may be before PBS listing) _____ (dd/mm/yyyy)

Patient's aetiology PPH PAH secondary to scleroderma

Is the patient on a transplant waiting list? Yes No

WHO Functional Class I II III IV

Other PAH specific medications prescribed epoprostenol sildenafil

iloprost Other 1

treprostinil Other 2

Thank you for participating in the Bosentan Patient Registry