



SOCIÉTÉ DE LA SCLÉROSE LATÉRALE AMYOTROPHIQUE DU QUÉBEC
AMYOTROPHIC LATERAL SCLEROSIS SOCIETY OF QUEBEC
LA MALADIE DE LOU GEHRIG'S DISEASE
www.sla-quebec.ca

REGISTRATION FORM

All questions are optional.

Identification of the person afflicted with ALS

Family name _____ name _____ M / F
gender _____

Address _____ city _____ postal code _____

Telephone (home) _____ telephone (cell) _____ telephone (work) _____ email _____

Birth date (day/month/year) _____ date of diagnostic (month/year) _____ When symptoms began (month/year) _____ Bulbar or Spinal _____

Correspondence language : F E Do you wish to receive our publications: yes no (electronic version printed)

Private medical insurance: Yes No Do you wish to participate in our conferences and support groups: yes no

Doctor who diagnosed ALS

Family name/name _____ medical center or hospital _____ telephone _____

Treating Neurologist

Family name/name _____ medical center or hospital _____ telephone _____

Family doctor

Family name/name _____ medical center or hospital _____ telephone _____

CLSC

CLSC : _____

Principal health care professional _____ professional title _____ telephone _____

Secondary health care professional _____ professional title _____ telephone _____

Readaptation Centre

Centre's name: _____

Principal health care professional _____ professional title _____ telephone _____

Secondary health care professional _____ professional title _____ telephone _____

Other Health Institution

Institution's name : _____

Principal health care professional _____ professional title _____ telephone _____

Principal Caregiver

Family name _____ first name _____ relation with afflicted person _____ date of birth
day / month / year _____

Address _____ city _____ postal code _____ Email _____

Telephone. (home) _____ telephone (work) _____ Cellular phone _____

Secondary Caregiver

Family name _____ first name _____ relationship with afflicted person _____ date of birth
day / month / year _____

Address _____ city _____ postal code _____ Email _____

Telephone. (home) _____ telephone (work) _____ Cellular phone _____

Children of the afflicted person : (use the reverse side if not enough space)

Family name _____ first name _____ birth date (day/month/year) _____

Family name _____ first name _____ birth date (day/month/year) _____

Family name _____ first name _____ birth date (day/month/year) _____

Family name _____ first name _____ birth date (day/month/year) _____

Family name _____ first name _____ birth date (day/month/year) _____

Other information

Referred to the ALS Society by : _____

Found out about the ALS Society by : newspaper internet radio television other : _____

Who filled out this form?

Afflicted person

Signature _____ date (day/month/year) _____

Other person Is the afflicted person aware of this registration? Yes No

Family name _____ first name _____ relationship with afflicted person _____

Signature _____ date (day/month/year) _____

PLEASE SEND THIS FORM TO THE ALS SOCIETY OF QUEBEC,
5415, rue Paré, Room 200, Mont-Royal, QC, H4P 1P7
or by FAX (514) 725-6184,
or to info@sla-quebec.ca