SLA ALS

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