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 diagnosed with ALS

_____ M / F
Last Name | first name | gender

_____
Address | city | postal code

(____) _____-_____ (____) _____-_____ (____) _____-_____ _____
Tel. : (home) | tel. : (mobile) | tel.: (work) | e-mail

____/____/_____ | _____/_____ | _____/_____ | F ☐ E ☐ | bulbar ☐ spinal ☐ | yes ☐ no ☐
Birth date (dd / mm / yyyy) | date of diagnostic (mm / yyyy) | when symptoms began (mm / yyyy) | language of correspondence | ALS form | private medical insurance

Do you work? yes ☐ no ☐ : Name of employer :_____ Title:_____

Young children (less than 18 y.o.) *(see reverse for adult children)*

Last name / first name | birth date dd / mm/ yy

_____ ___/___/___
_____ ___/___/___
_____ ___/___/___
_____ ___/___/___

Do you wish to receive our publications :
yes ☐ no ☐ electronic version ☐ printed ☐

Do you wish to participate in our support groups :
yes ☐ no ☐

Would you like to be paired with another person with ALS?
yes ☐ no ☐

Would you like to receive friendly visits? yes ☐ no ☐

Doctor who diagnosed ALS

_____
Last / First name | medical center or affiliation | telephone

Treating neurologist

_____
Last / First name | medical center or affiliation | telephone

Family doctor

_____
Last / First name | medical center or affiliation | telephone

CLSC/CSSS/CIUSSS

Name of CLSC/CSSS/CIUSSS : _____

_____
Name of health care professional | professional title | email | telephone

_____
Name of health care professional | professional title | email | telephone

Rehabilitation centre

Name of the centre : _____

_____
Name of health care professional | professional title | email | telephone

Identification of the primary caregiver

Last Name _____ first name _____ relationship with the diagnosed person _____ birth date dd / mm / yyyy _____

Address _____ city _____ postal code _____

(____) _____-_____ tel. : (home) (____) _____-_____ tel. : (mobile) (____) _____-_____ tel.: (work) e-mail _____

Do you work? : Name of employer : _____

Part-time ☐ full-time ☐ I do not work ☐

How many weekly hours do you devote to the afflicted person? :

1-4 hours ☐ 5-9 hours ☐

10-19 hours ☐ 20 hours & more ☐

Are you a caregiver to another person? yes ☐ no ☐

Do you wish to receive our publications?

yes ☐ no ☐ electronic version ☐ printed ☐

Do you wish to participate in our support groups :

yes ☐ no ☐

Would you like to be paired with another caregiver?

yes ☐ no ☐

Other caregivers and/or adult children

1) _____

Last name _____ first name _____ relationship with the diagnosed person _____ birth date (dd / mm / yyyy) _____

Address _____ city _____ postal code _____

caregiver ☐ child ☐ (____) _____-_____ tel. : (home) (____) _____-_____ tel. : (mobile) e-mail _____

2) _____

Last name _____ first name _____ relationship with the diagnosed person _____ birth date (dd / mm / yyyy) _____

Address _____ city _____ postal code _____

caregiver ☐ child ☐ (____) _____-_____ tel. : (home) (____) _____-_____ tel. : (mobile) e-mail _____

3) _____

Last name _____ first name _____ relationship with the diagnosed person _____ birth date (dd / mm / yyyy) _____

Address _____ city _____ postal code _____

caregiver ☐ child ☐ (____) _____-_____ tel. : (home) (____) _____-_____ tel. : (mobile) e-mail _____

Other information

Were you referred to become a member of the ALS Society of Quebec? If yes, by whom: _____

How did you find out about the ALS Society of Quebec?: newspaper ☐ internet ☐ radio ☐ television ☐ other (specify):_____

Who completed this form?

Self(diagnosed with ALS) ☐

Signature _____ date (dd / mm / yyyy) _____

Other person ☐ If other, is the person diagnosed with ALS aware of this membership registration? yes ☐ no ☐

Family name _____ given name _____ relationship with the diagnosed person _____

Signature _____ date (dd / mm / yyyy) _____

PLEASE SEND THIS FORM TO THE ALS SOCIETY OF QUEBEC

5415 Paré St., Suite 200, Mont-Royal, QC H4P 1P7

or by **FAX at (514) 725-6184**

or at **info@sla-quebec.ca**