



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

Please answer all questions.

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 | birth date |
| _____ | _____ | _____ | _____ |
| address | city | postal code | Email |
| _____ | _____ | _____ | _____ |
| Telephone. (home) | telephone (work) | | Cellular phone |

Secondary Caregiver

| | | | |
|-------------------|------------------|------------------------------------|----------------|
| _____ | _____ | _____ | _____ |
| family name | first name | relationship with afflicted person | birth date |
| _____ | _____ | _____ | _____ |
| 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, Local 200, MONTRÉAL, QC, H4P 1P7
 OR BY FAX (514) 725-6184
 OR TO info@sla-quebec.ca