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

Last Name ____________ first name ____________ M / F gender

Address ____________ city ____________ postal code ____________

(_____) ______-________ Tel. : (home)
(_____) ______-_________ tel. : (mobile)
(_____) ______-________ tel.: (work)
____________ e-mail

____/____/_______ Birth date (dd / mm / yyyy)

_________/_______ date of diagnostic (mm / yyyy)

_________/_______ when symptoms began (mm / yyyy)

F ☐ E ☐ language of correspondence

bulbar ☐ spinal ☐ ALS form

yes ☐ no ☐ 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 primary health care professional ____________ professional title ____________ telephone ____________

Name of secondary health care professional ____________ professional title ____________ telephone ____________

Rehabilitation centre

Name of the centre : ____________

Name of primary health care professional ____________ professional title ____________ 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**