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 FOR THE PERSON DIAGNOSED WITH ALS

All questions are optional

Confidentiality statement

The ALS Society of Quebec respects your privacy. We protect your personal information and adhere to all legislative requirements with respect to confidentiality. We do not rent, sell or trade our mailing lists. The information you provide will be used to deliver services and to keep you informed and up to date on the activities of the ALS Society of Quebec, including newsletters, programs, services and special events. Only authorized personnel have access to any identifying information. Please notify us of any changes by phone at 1 877 725-7725 or via email at info@sla-quebec.ca.

I certify that I have read and understood the implications of the above privacy statement. ☐

Identification of the person diagnosed with ALS

Family name _____ Given name _____ M / F / Other Gender

Address _____ City _____ Postal code

(____) _____-_____ Tel. : (Home) (____) _____-_____ Tel. : (Mobile) (____) _____-_____ Tel.: (Work) _____ E-mail address

____/____/_____ Date of birth (dd / mm / yyyy) _____/_____ Date of diagnosis (mm / yyyy) _____/_____ Date of first symptoms (mm / yyyy) F ☐ E ☐ Language of correspondence Bulbar ☐ Spinal ☐ Form of ALS Yes ☐ No ☐ Private medical insurance

Do you work? Yes ☐ No ☐ : Name of employer : _____ Title: _____

Treating Neurologist

Family / Given name _____ Medical center or affiliation _____ Telephone

Doctor who diagnosed ALS

Family / Given name _____ Medical center or affiliation _____ Telephone

Family Doctor

Family / Given name _____ Medical center or affiliation _____ Telephone

CLSC/CSSS/CIUSSS

Name of CLSC/CSSS/CIUSSS : _____

Name of health care professional _____ Professional title

Email address _____ Phone number

Name of health care professional _____ Professional title

Email address _____ Phone number

Identification of the primary caregiver

Family Name _____ Given name _____ M / F/ Other Gender

Relationship with the diagnosed person _____ Date of birth (dd / mm / yyyy)

Address _____ City _____ Postal code

(____) _____-_____ (____) _____-_____ (____) _____-_____ _____
Tel. : (Home) Tel. : (Mobile) Tel.: (Work) E-mail address

Do you work? : Part-time ☐ Full-time ☐ I do not work ☐ Name of employer :

Other caregivers and/or adult children

1) Family name _____ Given name _____ M / F/ Other Gender

Relationship with the diagnosed person _____ Date of birth (dd / mm/ yyyy)

Address _____ City _____ Postal code

Caregiver ☐ Child ☐ (____) _____-_____ (____) _____-_____ _____
Tel. : (Home) Tel. : (Mobile) E-mail address

2) Family name _____ Given name _____ M / F/ Other Gender

Relationship with the diagnosed person _____ Date of birth (dd / mm/ yyyy)

Address _____ City _____ Postal code

Caregiver ☐ Child ☐ (____) _____-_____ (____) _____-_____ _____
Tel. : (Home) Tel. : (Mobile) E-mail address

Other information

Referred to the Society by:_____

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 person diagnosed with ALS

Signature _____ Date (dd / mm / yyyy)

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