

Application to add a person to an existing membership

DETAILS OF EXISTING MEMBERSHIP

Mr/Mrs/Miss/Ms/Dr (please circle) First Name: Surname:

Member ID (if known):

Address:

State: Post Code:

Home Phone Mobile

Email:

DETAILS OF PERSON TO BE ADDED TO MEMBERSHIP

Mr/Mrs/Miss/Ms/Dr (please circle) First Name: Surname:

Relationship to person named above

Mobile Email:

Date of Birth: / / Gender: Male Female

Occupation: Pension No: (If Applicable)

Diagnosis: Coeliac Disease Dermatitis Herpetiformis Gluten Intolerance*

**Gluten intolerance - A person who does not have CD or DH but is diagnosed as requiring a gluten free diet by a registered medical practitioner*

YOUR APPLICATION FOR MEMBERSHIP MUST BE SUPPORTED BY A REGISTERED MEDICAL PRACTITIONER.

Your doctor may sign below or you may attach a letter confirming the diagnosis

I, confirm that the above named individual requires a gluten free diet due to the diagnosis indicated.

Doctor's Signature: Date:

Provider Number:

Practice Name & Address:

Gastroenterologist GP Other registered medical practitioner

QUESTIONNAIRE

Please provide information about the person diagnosed with coeliac disease, dermatitis herpetiformis or gluten intolerance

1. Name:

2. Age diagnosed? years

3. Please indicate which diagnostic tests were performed:

- Small bowel biopsy (by endoscopy/gastroscopy) Blood Screening Test
 Skin Biopsy (for Dermatitis Herpetiformis) Coeliac Genetic Testing (HLA Genes)
 Other testing

4. Were any of the following related symptoms experienced prior to diagnosis?

- Abdominal Distension/Bloating Diarrhoea Constipation
 Vomiting and/or Nausea Weight loss Infertility
 Iron Deficiency Anaemia No symptoms (asymptomatic)

5. At the time of diagnosis, were any of the following conditions, thought to be associated with coeliac disease, present?

- Type 1 (Juvenile onset) diabetes Turner's syndrome IgA deficiency
 Osteoporosis or Osteopaenia Sjogren's syndrome Down's syndrome
 Autoimmune Thyroid Condition Rheumatoid Arthritis Small bowel lymphoma
 Lactose Intolerance

6. Period of feeling unwell prior to diagnosis?

- Not unwell < 6 months 6 - 12 months 12 - 24 months > 24 months

7. Is there a family history of coeliac disease? Yes No

8. How did you find out about Coeliac NSW/ACT?

- Doctor Dietitian Website A friend or family member
 Other:

9. What prompted you to join Coeliac NSW/ACT? (you may select more than one)

- Instruction from Doctor New member pack
 The Australian Coeliac magazine The Ingredient List Booklet
 For access to member support and events The Coles Discount Card
 Other

I hereby apply to become a member of the abovenamed incorporated association. If I am admitted as a member, I agree to be bound by the rules of the association for the time being in force.

Signature *Date*

(signed by person diagnosed if aged over 18 years, or by parent/guardian)

OFFICE USE ONLY

Date Member ID What Now (if applicable)

Web - June 2011