

# APPLICATION FOR MEMBERSHIP

(Incorporated under the Associations Incorporation Act, 1984)

- If the person diagnosed is over 16, please complete sections A and C of this form
- If the person diagnosed is under 16 years or being cared for, please complete sections A, B and C

## SECTION A: DETAILS OF PERSON DIAGNOSED

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

Postal Address:

State: Post Code:

Residential Address: (if different from above)

State: Post Code:

Home Phone Work Phone

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 doesn't have CD or DH but requires a gluten free diet as diagnosed by a registered medical practitioner

## SECTION B: DETAILS OF PARENT OR GUARDIAN

(TO BE COMPLETED IF PERSON DIAGNOSED IS UNDER 16 YEARS OR BEING CARED FOR)

Relationship to person named in Section A  Parent/Guardian  Carer

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

Postal Address (If different to address provided above; This address will be used for all correspondence)

State: Post Code:

Work Phone Mobile

Email: Occupation:

Date of Birth: / / Gender:  Male  Female

## SECTION C: 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)
- Skin Biopsy (for Dermatitis Herpetiformis)
- Other testing .....
- Blood Screening Test
- Coeliac Genetic Testing (HLA Genes)

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

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

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
- Osteoporosis or Osteopaenia
- Autoimmune Thyroid Condition
- Lactose Intolerance
- Turner's syndrome
- Sjogren's syndrome
- Rheumatoid Arthritis
- IgA deficiency
- Down's syndrome
- Small bowel lymphoma

6. Period of feeling unwell prior to diagnosis?

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

7. Is there is 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
- The Australian Coeliac magazine
- For access to member support and events
- Other .....
- New member pack
- The Ingredient List Booklet
- The Coles Member Discount Card

### 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

