

Galactosaemia Support Group
Registration Form for Adult Galactosaemics



Title : Mr / Mrs / Miss / Ms / Other (please state)

Surname/s :
.....

First Names :

Address :
.....

.....Post Code :

Telephone Number : Email :

Date of birth :

Brothers & Sisters names and dates of birth :
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.....

Information about yourself

Age when diagnosed :

Hospital where you were born :

Hospital where your diagnosis was made :

Which hospital do you attend for clinical follow up :

Name of current consultant :

Name of current dietitian :

Have you had trouble gaining information on galactosaemia from your medical team? Yes / No

Do you work? If yes, what is your job?

Have you experienced any problems since diagnosis eg. Cataracts, speech delay, educational problems, difficulty finding work, making friends etc?
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Do you give permission for your contact details to be passed on to other family members of the support group? Yes / No

I enclose a bankers order form or cheque for £25.

Signed Date