

Galactosaemia Support Group  
Registration Form for family members



Parents / Guardians Details

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

Surname/s :

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First Names : .....

Address : .....

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.....Post Code : .....

Telephone Number : ..... Email : .....

Galactosaemic Child/Children's names and dates of birth

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Siblings names and dates of birth

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Information about your galactosaemic child/children

Age when diagnosed : .....

Hospital where child was born : .....

Hospital where 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

Has your child experienced any problems since diagnosis eg. Cataracts, speech delay, educational problems, other? (Obviously this question is not applicable to new borns)

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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

If your child was born after 1<sup>st</sup> January 1994 has your consultant talked to you about the galactosaemia register? Yes / No

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

Signed ..... Date .....