Galactosaemia Support Group
Registration Form for Adult Galactosaemics

Charity number 1020167
www.galactosaemia.org

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

Surname: ______________________

First name: ______________________

Address: ______________________

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______________________ Postcode: ______________________

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 ______________________

Please return to: GSG, 31 Cotysmore Road, Sutton Coldfield, West Midlands, B75 6BJ