Galactosaemia Support Group
Registration Form for Family Members

Charity number 1020167
www.galactosaemia.org

Parents / Guardians Details:

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

Surname: _____

First name: _____

Address: _____

_____

_____ Postcode: _____

Telephone number: _____ Email: _____

Galactosaemics name and date of birth: _____

Sibling(s) name(s) and date(s) of birth: _____

_____

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)

_____

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 1st 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 _____

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