



2010-11 ADULT MEMBERSHIP REGISTRATION FORM

The information you supply is confidential and will only be used to establish a true portrait of our membership in order to be able to adapt our programs in consequence.

CONTACT INFORMATION

First name: _____ Family name: _____
 Address: _____
 City: _____ Province: _____
 Postal Code: _____ Telephone: (____) _____
 E-mail: _____ Tel. (Work): (____) _____
 Date of birth: _____

Your signature here signifies your refusal for us to give your coordinates to the Canadian Hemophilia Society - National Chapter (CHS). Otherwise, we will pass them along so that you can be a member and receive the quarterly newsletter, *Hemophilia Today*, as well as other information.

Signature: _____

I authorize the CHSQ to use my name and telephone number in order to create an address book that will be sent only to members of the organisation. All other information on this form will remain confidential.

Signature: _____

You are a person with a bleeding disorder (including carriers).

Type of bleeding disorder	Level of severity	Inhibitors	Infection(s) due to treatment related to your bleeding disorder
<input type="checkbox"/> Factor VII <input type="checkbox"/> Factor VIII <input type="checkbox"/> Factor IX <input type="checkbox"/> Factor XIII <input type="checkbox"/> Von Willebrand <input type="checkbox"/> Carrier <input type="checkbox"/> Other ? Which disorder? _____	<input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Mild	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> HIV <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Other: _____ _____

Treatment

Treatment centre: _____ Treating doctor: _____

Where your treating doctor practices (if different from the treatment centre): _____

Type of treatment

Product used: _____ Approximate number of bleeding episodes per month? _____

Have you started prophylaxis? _____ How often? _____ / week

If you have inhibitors, have you begun immune tolerance? _____

You are related to someone (people) with a bleeding disorder.

What is your relation to this person (these people)? _____

Please indicate his/her/their name(s)? _____

You are a person who was infected through a blood transfusion.

Date of transfusion: _____

Infection(s) from a blood transfusion: HIV Hepatitis C Other: _____

