

**So. Az. Celiac Support, CSA Chapter 15, Tucson**  
**Celiac Screening 2009 REGISTRATION FORM**  
**Saturday May 9<sup>th</sup>, 9am-2 pm**

**PLEASE PRINT CLEARLY**

LAST: \_\_\_\_\_ First: \_\_\_\_\_ M F DOB: \_\_\_/\_\_\_/\_\_\_

Address: ( ) ( ) ( ) ( ) \_\_\_\_\_ City \_\_\_\_\_ ST ( ) ( )  
Street Number Dir Street Name

Home Phone: ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) Cell Phone: ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) Zip ( ) ( ) ( ) ( )

Email address: \_\_\_\_\_ Contact Preference \_\_\_\_\_

I learned of this test via Web\_\_ NPaper\_\_ TV\_\_ Radio\_\_ Friend\_\_ Pima Co. Fair\_\_ Store\_\_ Other\_\_

Preferred Test Time on Saturday, May 9<sup>th</sup>, 2009: 9-10 \_\_\_\_\_ 10-11 \_\_\_\_\_ 11-12 \_\_\_\_\_

**Please read the following information carefully:**

Screening participants must be 18 years old, or greater. Preference will be given to applicants with a family member who has biopsy-proven Celiac Disease and/or SACS affiliates.

I understand that today's screening test is **not** a final diagnosis of a medical condition and this screening test is not a substitute for expert medical care. I understand that all participants will be notified of their test results by mail within 3-4 weeks of the test date. Participants who test positive will receive a phone call from a SACS Executive Board Member or Medical Advisory Board Member before their letter is sent.

I understand that if my test is negative **and** I have a risk factor for celiac disease, that I will need testing again in the future. I also understand that if my test is positive, this is **not** a diagnosis of celiac disease but an indication that **further medical evaluation is necessary.**

Testing information is released only to the individual tested.

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Your signature \_\_\_\_\_ Date \_\_\_\_\_

Please mail this form to: **SACS Medical Advisory Board**  
**c/o 11605 E. Golf Links Rd**  
**Tucson , AZ 85730**

**OR**

Sign, Scan & Email to: [so.az.celiacsupport@earthlink.net](mailto:so.az.celiacsupport@earthlink.net)

**PLEASE TURN OVER FOR AN IMPORTANT QUESTIONNAIRE →**  
(which must be filled out in order to be considered as a candidate)

I. Have you been following a gluten-free diet? **No** \_\_\_\_ **Yes** \_\_\_\_ (how long? \_\_\_\_\_)

II. The following checklist is very important to us for future research studies. Please place a check mark by any risk factor that *may apply* to your reason for being tested for celiac disease (CD) today:

\_\_\_\_\_ Mother, Father, Sister, Brother, Son, Daughter with (check one or both if applicable):  
\_\_\_\_\_ biopsy-confirmed CD and/or \_\_\_\_\_ positive blood test for CD

\_\_\_\_\_ Aunt, Uncle, Cousin, Grandparent of an individual with (check one or both if applicable):  
\_\_\_\_\_ biopsy-confirmed CD and/or \_\_\_\_\_ positive blood test for CD

\_\_\_\_\_ Dermatologic condition (ttg much less reliable; urge to see a doctor): Specify: \_\_\_\_\_

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\_\_\_\_\_ Autoimmune disorders:

\_\_\_\_\_ Type 1 diabetes

\_\_\_\_\_ Sjogren's syndrome

\_\_\_\_\_ Thyroiditis

\_\_\_\_\_ Vitiligo

\_\_\_\_\_ Rheumatoid arthritis

\_\_\_\_\_ Autoimmune hepatitis

\_\_\_\_\_ Addison's Disease

\_\_\_\_\_ Myasthenia Gravis

\_\_\_\_\_ You are the mother, father, sister, brother, son or daughter of a person with Type 1 diabetes

\_\_\_\_\_ Iron-Deficiency Anemia (that has not responded to iron therapy) and fatigue

\_\_\_\_\_ Persistent gastrointestinal symptoms (diarrhea, constipation, bloating, gas, abdominal pain)

\_\_\_\_\_ Dental enamel hypoplasia

\_\_\_\_\_ Aphthous Stomatitis (canker sores/mouth ulcers)

\_\_\_\_\_ Osteopenia/Osteoporosis

\_\_\_\_\_ Joint Pain

\_\_\_\_\_ Fibromyalgia

\_\_\_\_\_ Unexplained Infertility/Miscarriage

\_\_\_\_\_ Depression

\_\_\_\_\_ Chronic fatigue

\_\_\_\_\_ Migraines

\_\_\_\_\_ Neurological

\_\_\_\_\_ Down Syndrome

\_\_\_\_\_ Turner's Syndrome

\_\_\_\_\_ William's Syndrome

\_\_\_\_\_ Other: \_\_\_\_\_

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