So. Az. Celiac Support, CSA Chapter 15, Tucson

Celiac Screening 2010 *REGISTRATION FORM*

Saturday April 24th, 9am-1 pm

PLEASE PRINT CLEARLY WITH A BLUE PEN

LAST: _____ **First**:_____ **M F DOB**:____/___/_____

Address:[ ][ ][ ][ ]_____ **City**_____ **ST**[ ][ ]
Street Number Dir Street Name

Home Phone:[ ][ ][ ]-[ ][ ][ ]-[ ][ ][ ][ ] **Cell Phone:**[ ][ ][ ]-[ ][ ][ ]-[ ][ ][ ][ ] **Zip**[ ][ ][ ][ ]

Email address: _____ **(results will be sent here)**
PLEASE WRITE "NONE" ONLY IF YOU DO NOT HAVE ACCESS TO AN EMAIL ADDRESS

I learned of this test via Web__ News Paper__ TV__ Radio__ Friend__ Store__ Other_____

***Preferred* Test Time on Saturday, April 24th, 2010**: **9-10**_____ **10-11**_____**11-12**_____**12-1**_____

Please read the following information carefully:

Preference will be given to applicants with a family member who has biopsy-proven Celiac Disease and/or SACS affiliates. By signing below **I affirm** that I am over 18 years of age and that I have *never been diagnosed* with either Celiac Disease (CD) or Dermatitis Herpetiformis (DH). I am **not** currently following a gluten-free diet (have been ingesting at least 50mg of gluten daily for six weeks or more).

I understand that today's screening test is ***not*** a final diagnosis of a medical condition nor is it a substitute for expert medical care. I understand that all participants will be notified of their test results within 4-5 weeks of the test date and that *I agree to allow my results to be sent via Email* unless otherwise noted above.

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, unless permission is granted in writing.

Your signature **Date**

Please mail this form to:

OR

SACS Medical Advisory Board
c/o 11605 E. Golf Links Rd
Tucson AZ 85730-5613

Sign, Scan & Email to: **so.az.celiacsupport@gmail.com**

PLEASE TURN OVER FOR AN IMPORTANT QUESTIONNAIRE →

(which *must be filled out* in order to be considered as a candidate)

I. Have you ever been diagnosed with CD, DH or gluten intolerance? **No**_____ **Yes**_____

(when?_____) dx via blood test ____ biopsy ____ stool____ pillcam____

II. Have you been following a gluten-free diet? **No** ____**Yes**____ (how long? _____)

III. The following checklist is very important to us for reference and possible 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: _____

_____

_____Autoimmune disorders:

_____Type 1 diabetes	_____Sjogren's syndrome	_____ Scleroderma
_____Thyroid disease	_____Vitiligo	_____Crohn's
_____Rheumatoid arthritis	_____Autoimmune hepatitis	_____Other _____
_____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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