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

Celiac Screening 2011 *REGISTRATION FORM*

Saturday April 30th, 10am-1pm

PLEASE PRINT CLEARLY WITH A PEN

Last: ___________________________**First**:____________________ **M F DOB**:____/___/______

Address: ____**City**______________________ **ST**____

Street Number Dir Street Name

Home Ph: __________________________**Cell Ph:** ___________________________ **Zip** ___________

Area Code 7-digit number Area Code 7-digit number

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__ Newspaper__ TV__ Radio__ Friend__ Store__ Other_________

***Preferred* Test Time on Saturday, April 30th, 2011**: **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 (I 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 **5-6 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 completed form to:

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

Your Choice of three ways to submit

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

***--OR--* FAX TOLL FREE TO**
1-866-392-9772

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(s) ____ 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

_______ Gluten Ataxia _______ Autism Spectrum _______ Bi-Polar

_______ Other: ____

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