Ataxia IRELAND

MEMBERSHIP FORM

FOR PERSON WITH AN ATAXIA

NAME: ……

ADDRESS: ……..

……

Telephone: …… **Mobile:** ……

E-mail: …… **Date of Birth:** ……

Type of Ataxia: *please tick relevant box*

- ☐ Friedreich's Ataxia
- ☐ Cerebellar Ataxia
- ☐ Episodic Ataxia
- ☐ Other

Genetic Diagnosis: ☐ Yes ☐ No

Other Information relating to Diagnosis (e.g. SCA No.): ……

……

Date/year of First Symptoms: ……

Neurologist: …… **Hospital:** ……

Please send information to me by: Post ☐ E-mail ☐

Membership No. …… *(office use only)*

4 Leopardstown Business Centre, Ballyogan Avenue, Dublin 18.
Tel: +353 1 2999 033 Fax: +353 1 2999 055
E-mail: info@ataxia.ie Website: www.ataxia.ie Chy. No: 7076

P.T.O.

MEMBERSHIP FORM

FOR FAMILY MEMBERS OF PERSON WITH AN ATAXIA

No. 1

NAME: ……

ADDRESS: ……..

……

Telephone: ……. **Mobile: …….**

E-mail: ……

Relationship to Ataxian: …….

Please send information to me by: Post ☐ E-mail ☐

Membership No. …… *(office use only)*

No. 2

NAME: ……

ADDRESS: ……..

……

Telephone: ……. **Mobile: …….**

E-mail: ……

Relationship to Ataxian: …….

Please send information to me by: Post ☐ E-mail ☐

Membership No. …… *(office use only)*

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