IDFNZ
Immune Deficiencies Foundation of New Zealand

MEMBERSHIP FORM

The Kids Foundation
www.idfnz.org.nz

☐ **Adult PID** ☐ **Youth PID (0-18)** ☐ **Youth Gastro Liver (0-18)**

Patient Member details

Name: _____

Address: _____

City/Post code: _____

Phone: _____ Mob: _____

Email: _____

Date of Birth: _____

Gender: Male/Female *(Circle one)*

Children's Birthday Club Member? Yes / No *(Circle one)*

Ethnicity: _____

NHI Number: _____ DHB: _____

Nominated Support Person / Next of Kin

(Main caregiver /contact - Voting member if patient under 18yrs)

Name: _____

Address: _____

City/Post code: _____

Phone: _____ Mob: _____

Email: _____

Relationship to patient member:

Who lives with patient member?(Registered as Associate members)

(Continue over page if needed)

Name: _____
Relationship: _____ DoB: _____

Name: _____
Relationship: _____ DoB: _____

Name: _____
Relationship: _____ DoB: _____

Name: _____
Relationship: _____ DoB: _____

Name: _____
Relationship: _____ DoB: _____

What is your current diagnosis?

- ☐ X-Linked Agammaglobulinemia (XLA)
- ☐ Ataxia Telangiectasia (A-T) (Louis Bar's)
- ☐ Chronic Granulomatous Disease (CGD)
- ☐ Common Variable (CVID)
- ☐ Complement Deficiency
- ☐ DiGeorge Syndrome
- ☐ Hyper IgM Syndrome (HIMS) all variants
- ☐ Neutropenia's (Kostmann's Syndrome)
- ☐ IgG Subclass Deficiency
- ☐ Selective IgA deficiency
- ☐ Severe Combined Immunodeficency (all varients)
- ☐ Wiskott - Aldrich syndrome (WAS)
- ☐ Acute Liver Failure (unknown Cause)
- ☐ Biliary Atresia
- ☐ Not sure
- ☐ Intestinal Failure
- ☐ Other

What treatments do/have you received?

- ☐ Intravenous Immunglobulin (IVIG) — How often? _____
- ☐ Subcutaneous Immunoglobulin (SCIG) — How often? _____
- ☐ Bone Marrow Transplantation (BMT) — When – date: _____
- ☐ None
- ☐ Kasia — When – date: _____
- ☐ Liver Transplant — When – date: _____
- ☐ Other
- ☐ TPN

Specialist's details

Name: _____

Contact: _____

Specialist's Signature: *(to verify medical details on this form)*

General Practitioner details

Name: _____

Practice: _____

Address: _____

_____

Please tell us about your interest and/or involvement with IDFNZ/KIDS Foundation:

_____

_____

_____

I (*name*)…… …Give IDFNZ permission to release my name and details to support staff / IDFNZ Medical panel in order to enable full participation and support by the Foundation. I understand that correspondence from the Foundation will be sent by email and/or mail. Date: ……

Please return the completed form to: IDFNZ Registration, PO Box 75-076, Manurewa, Manukau, 2243 Auckland.

Confirmation of membership will be sent by mail and/or email.

*Note: IDFNZ requires A Medical specialist to complete section *overleaf for applications to be accepted. IDFNZ reserves the right to updated medical information when requested to accurately maintain our records.*

Office use only

Family matching: *Yes/No*

Birthday Club: *Yes/No*

*Entered database:*_____ *Date:* _____

Adult PID Patient Member (Voting)	A
Youth Patient Member (Non-voting)	B
Support Member PID (Voting)	C
Support Member NON-PID (Voting)	D
Associate Member (Non-voting)	E
Honorary Member (Voting)	F