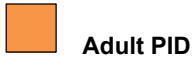


MEMBERSHIP FORM



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: _____

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 Immunodeficiency (all variants)
- 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)
- Subcutaneous Immunoglobulin (SCIG)
- Bone Marrow Transplantation (BMT)
- None
- Kasia
- Liver Transplant
- Other
- TPN

How often? _____
 How often? _____
 When – date: _____
 When – date: _____
 When – date: _____

Specialist's details

Name: _____
 Contact: _____

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

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: _____

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