Muscular Dystrophy Foundation India

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Email: info@mdfindia.org website: http://www.mdfindia.org

Patient Registration Form

Name of the Patient	Date of Birth	Age	Sex		Type of Muscular Dystrophy Please tick (√) the right one					Others (specify)
			Male	Female	DMD	BMD	SMA	CMD	LGMD	

Part-I (Details about the Patient)

Details of diagnosis	Type of the diagnosis test/s conducted. Please tick (√) all those applicable □ DNA/Gene test □ Muscle Biopsy □ Others Name of the Lab/doctor:... Date of diagnosis:............................... Result of the DNA/Muscle biopsy test: .... **(Please attach a scan/photocopy of the Genetic test/muscle biopsy report ONLY)**
Present physical condition	Is the patient walking at present □ Yes □ No Is the patient able to stand? □ Yes □ No Is the patient able to sit straight? □ Yes □ No Is the patient able to eat on his/her own? □ Yes □ No Would you like to mention anything specific about the physical / health condition of the patient? ....
Education details	Is the patient going to school/college at present? □ Yes □ No. If Yes, in which standard? .... Name of the School/College: .... If not going to school/College, up to which standard the patient studied? .... Why is the patient not going to school/college? Please tick (√) the reason that best suits you. □ Patient is not interested □ Mobility is a problem □ Health is not good □ Not permitted by the school/college What is the educational qualification, if the patient is an adult? ....
Employment details	Is the patient presently employed? □ Yes □ No. If Yes, please provide the following details Designation / Nature of work | Name of the company / department | Date of joining | Income per month
Marriage details	Is the patient married □ Yes □ No If yes, please mention the year of marriage :................. Is the spouse of the patient a relative even before the marriage? □ Yes □ No How many children? ....M .... Female
Government aid/ assistance	Does the patient have a National Disability Identity Card? □ Yes □ No If yes, please mention the ID card Number:............................ **(Please attach a photocopy of your National disability identity card)** Does the patient receive the monthly maintenance grant of Rs.1000/- p.m from the government? □ Yes □ No If no, please state as to whether the patient has applied for the grant? □ Yes □ No

Part -2 (Details of Patient's Family)

Name of the father / guardian of the patient...................................... Age .... Occupation: ……………………………………….

Place of working ....Please provide details of all the members in the family of the patient

#	Name of the family members	Sex		Age	Relation	Is s/he a muscular dystrophy patient		Educational qualification	Occupation	Monthly income
		M	F			Yes	No			

Is there a friend or relative of yours being afflicted with muscular dystrophy? □ Yes □ No
If yes, please provide their details as follows

#	Name of the person afflicted with muscular dystrophy	Sex		Age	Phone with STD code & Mobile no	Type of relation with you
		M	F			

Are you and the patient willing to join Muscular Dystrophy Foundation India? □ Yes □ No
If no, please specify the reason? ....

Contact details

Door No. .... Street: …………………………………………………………………………………………………….

Area:...Post:...............................

Taluk/District:......................................Pincode:.........................Email ID:

Phone with STD code: ....Mobiles...

Declaration

I, ... hereby declare that the information provided above is true to the best of my knowledge. It is solely at the interests of my son/daughter/relative that I voluntarily submit all personal information through this form. I do hereby fully and unconditionally consent to authorize MDF INDIA to use all those information provided by me in this registration form in any manner required by them from time to time for the betterment of muscular dystrophy patients and their families.

Signature: Date :