



FASI 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)*



FASI 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)