

**Southern Arizona Celiac Support Group (SACS)
CSA Chapter 15, Tucson
Celiac Screening 2008 *REGISTRATION FORM*
Saturday May 10th, 9-1 pm**

Name: _____ DOB: _____

Address: _____ City _____ Zip _____

Email address: _____

Home Phone: _____ Cell Phone: _____

Preferred Test Time on Saturday, May 10, 2008: 9-10___ 10-11___ 11-12___ 12-1___

Please read the following information carefully:

Screening participants must be 18 years old, or greater. Preference will be given to applicants with a family member who has biopsy-proven Celiac Disease and/or SACS affiliates.

I understand that today's screening test is not a final diagnosis of a medical condition and a screening test is not a substitute for expert medical care. I understand that all participants will be notified of their test results by mail within 3-4 weeks of the test date. Participants who test positive will receive a phone call from a SACS Executive Board Member or Medical Advisory Board Member before their letter is sent.

I understand that if my test is negative **and** I have a risk factor for celiac disease, that I will need testing again in the future. I also understand that if my test is positive, this is *not* a diagnosis of celiac disease but an indication that **further medical evaluation is necessary**.

Testing information is released only to the individual tested.

Your signature

Date

Please mail this form to:

**SACS Medical Advisory Board
6470 East Via Amable
Tucson , AZ 85750**

OR

Sign, Scan & Email to:

shellihanksmd@yahoo.com

PLEASE TURN OVER FOR AN IMPORTANT QUESTIONNAIRE →

I. Have you been following a gluten-free diet? ___ No ___ Yes (how long? _____)

II. The following checklist is very important to us for future research studies. Please place a check mark by any risk factor that may apply to your reason for being tested for celiac disease today:

_____ Mother, Father, Sister, Brother, Son, Daughter with biopsy-confirmed celiac disease

_____ Aunt, Uncle, Cousin, Grandparent of an individual with biopsy-confirmed celiac disease

_____ Dermatologic condition (ttg much less reliable; urge to see a doctor): Specify: _____

_____ Autoimmune disorders:

_____ Type 1 diabetes

_____ Sjogren's syndrome

_____ Thyroiditis

_____ Vitiligo

_____ Rheumatoid arthritis

_____ Autoimmune hepatitis

_____ Addison's Disease

_____ Myasthenia Gravis

_____ You are the mother, father, sister, brother, son or daughter of a person with type 1 diabetes

_____ Iron-Deficiency Anemia (that has not responded to iron therapy) and fatigue

_____ Dental enamel hypoplasia

_____ Osteopenia/Osteoporosis

_____ Unexplained Infertility/Miscarriage

_____ Chronic fatigue

_____ Persistent gastrointestinal symptoms (diarrhea, constipation, bloating, gas, abdominal pain)

_____ Down Syndrome

_____ Turner's Syndrome

_____ Williams Syndrome

_____ Other: _____

