



The Coeliac Society

of Victoria

ABN 75 785 779 882

PO Box 89

HOLMESGLEN VIC 3148

9-11 Barlyn Road

MT WAVERLEY VIC 3149

Phone: 03 9808 5566

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Office Use Only

Member ID:

Date:

Receipt No:

Application for Membership

If you are over 18 years and completing this form, **please complete sections A and C**

If the person diagnosed is under 18 years or being cared for, **please complete sections A, B and C**

SECTION A: Details of person diagnosed

Mr/Mrs/Miss/Ms/Dr (please circle) First Name: Surname:

Postal Address:

..... State: Post Code:

Residential Address: (if different from above)

..... State: Post Code:

Home Phone: Work Phone:

Mobile: Email:

Date of Birth: / / Gender: Male Female

Occupation:

Diagnosis: Coeliac Disease Dermatitis Herpetiformis Gluten Intolerance*

*Gluten intolerance – A person who does not have CD or DH but is diagnosed as requiring a gluten free diet by a registered medical practitioner

SECTION B: Details of parent or guardian (To be completed if person diagnosed is under 18 years or being cared for)

Relationship to person named in Section A Parent/Guardian Carer

Mr/Mrs/Miss/Ms/Dr (please circle) First Name: Surname:

Postal Address (If different to address provided above – this address will be used for all billing correspondence)

..... State: Post Code:

Work Phone: Mobile:

Email: Occupation:

Date of Birth: / / Gender: Male Female

Please Note: Your application for membership must be supported by a registered medical practitioner.

Your doctor may sign below or you may attach a letter confirming the diagnosis

I, confirm that the above named individual requires a gluten free diet due to the diagnosis indicated in Section A.

Doctor's Signature: Date:

Provider Number:

Practice Name & Address:

Gastroenterologist GP

Description	Price	Total
New Membership (full rate) – Covers Joining Fee, Great Start Kit plus subscription - four (4) issues of The Australian Coeliac Magazine – Sept & Dec 2010, and March & June 2011. (Subs are calculated by calendar year) - you will also be provided a bonus issue - June 2010.	\$87.00	\$
OR (concession rate) Centrelink Card No. _____ Valid until Date: _____	\$70.00	\$
** PLEASE ALSO ADD THE FOLLOWING ITEMS TO MY ORDER:	Qty	
Ingredient List 8 th Edition – extra copy*		\$7.50 \$
Gluten Free Travel Guide		\$15.95 \$
Living Gluten Free for Dummies		\$28.95 \$
Coeliac Society Recipe Book – extra copy		\$15.00 \$
Coeliac Society Handbook – extra copy		\$10.00 \$
Toast a bags (pack of two)		\$14.00 \$
What's Cooking (recipes for kids)		\$13.75 \$
Amy Can't Eat Gluten (story book)		\$6.60 \$
Cassie The Croc has Coeliac Disease (story book)		\$10.00 \$
	Total:	\$

* Included in Great Start Kit - extra copies can be purchased

**Note: Items ordered with New Membership do not incur extra postage charges.

PAYMENT DETAILS & APPLICATION CHECKLIST

- Application Form
- Confirmation of diagnosis from a registered medical practitioner
- Payment (below)

Payment options

- Cheque or money order payable to 'The Coeliac Society of Victoria Inc
- Credit card:

Visa Mastercard Authorised Amount:

Card Number: _____ / _____ / _____ / _____ Expiry Date: ____/____

CCV No. _____ (last 3 digits on signature panel)

Cardholder Name Signature

**The Coeliac Society is here to inform, understand and support you with your gluten free lifestyle
 We are happy to offer assistance - Opening Hours are Mon-Fri, 10am to 3pm
 Please don't hesitate to contact us with any queries - 1300 458 836**

Prices valid until 30 September 2010

SECTION C: QUESTIONNAIRE

Please provide information about the person diagnosed with coeliac disease, dermatitis herpetiformis or gluten intolerance

1. Name:
2. Age diagnosed?(years)
3. Please indicate which diagnostic tests were performed:
 - Small bowel biopsy (by endoscopy/gastroscopy)
 - Blood Screening Test
 - Skin Biopsy (for Dermatitis Herpetiformis)
 - Coeliac Genetic Testing (HLA Genes)
 - Other testing:
4. Were any of the following related symptoms experienced prior to diagnosis?
 - Abdominal Distension/Bloating
 - Diarrhoea
 - Constipation
 - Vomiting and/or Nausea
 - Weight loss
 - Infertility
 - Iron Deficiency Anaemia
 - No symptoms (asymptomatic)
5. At the time of diagnosis, were any of the following conditions, thought to be associated with coeliac disease, present?
 - Type 1 (Juvenile onset) diabetes
 - Turner's syndrome
 - IgA deficiency
 - Osteoporosis or Osteopaenia
 - Sjogren's syndrome
 - Down's syndrome
 - Autoimmune Thyroid Condition
 - Rheumatoid Arthritis
 - Small bowel lymphoma
 - Lactose Intolerance
6. Period of feeling unwell prior to diagnosis?
 - Not unwell
 - < 6months
 - 6 – 12months
 - 12 – 24months
 - > 24months
7. Is there is a family history of coeliac disease? Yes No
8. How did you find out about The Coeliac Society?
 - Doctor
 - Dietitian
 - Website
 - Friend or family member
 - Other
9. What prompted you to join The Coeliac Society? (you may select more than one)
 - Instruction from Doctor
 - To receive new member pack
 - To receive The Australian Coeliac magazine
 - To receive the Ingredient List Booklet
 - For access to member support and events
 - To receive the Coles Discount Card
 - Other

State Privacy Statement

The Coeliac Society of Victoria collects and uses your personal information to provide you with information about coeliac disease, products for a gluten free diet and research. We use de-identified personal information to compile statistics which assist us to understand coeliac disease better. We will only disclose your contact information to our mailing house and other relevant contractors with whom we have a Privacy Agreement.

I hereby apply to become a member of the abovenamed incorporated association. If I am admitted as a member, I agree to be bound by the rules of the association for the time being in force. I acknowledge that, along with regular Society information, I may receive information and advertisements from manufacturers of products suitable for use in a gluten free diet and research.

Signature: Date:/...../.....
(signed by person over the age of 18 years)