**Amyotrophic Lateral Sclerosis Disease Registry**

Massachusetts Department of Public Health

**Report Form**

**Date of Report:** \_\_\_\_\_/ \_\_\_\_\_/ \_\_\_\_\_\_\_\_\_\_\_

**Reporting Information:**

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person completing this form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*In the future, please contact the following person for these requests:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check the appropriate box:**

[ ]  **Yes** - I evaluated or diagnosed ALS cases between **January 1 and December 31, \_\_\_\_\_\_(YEAR)** *(Please list patients and* ***mail*** *to the address provided)*

[ ]  **Yes** - As a representative of my department, the following patients were evaluated for or diagnosed with ALS between **January 1 and December 31, \_\_\_\_\_(YEAR)**  *(Please list patients and* ***mail*** *to the address provided)*

[ ]  **No -** I or my department did not evaluate or diagnose ALS cases between **January 1 and December 31, \_\_\_\_\_(YEAR)** *(Report form may be faxed to 617-624-5778)*

|  |  |  |  |
| --- | --- | --- | --- |
| **First Name** | **Last Name** | **Medical Record Number** |  **DOB** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Patient Information:**

***Please mail or fax this form to:***

 ***MDPH-Bureau of Environmental Health***

**c/o ALS Registry Coordinator**

***250 Washington Street, 7th Floor***

***Boston, MA 02108***

***Phone: (617) 624-5757***

***FAX: (617) 624-5778***