Amyotrophic Lateral Sclerosis Disease Registry
Massachusetts Department of Public Health
Report Form

Date of Report: _____/ _____/ _____

Reporting Information:

Name of Facility: _____ Phone: _____
Street: _____ E-mail: _____
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)*

Patient Information:

First Name	Last Name	Medical Record Number	DOB

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

**If reporting for your entire practice or clinic, please include a list of all physicians. Thank you.