U. K. Thalassaemia Society
19 The Broadway
London, N14 6PH.

MEMBERSHIP APPLICATION FORM

ALL DETAILS AND INFORMATION WILL BE KEPT ON OUR COMPUTERS AND WILL REMAIN IN THE OFFICE AND WILL NOT BE MADE AVAILABLE TO ANYBODY OUTSIDE OF THE UKTS.
If however you do not wish your details kept on our computers please tick this box ☐

Charity Reg No: 275107

YOUR PERSONAL DETAILS

Title (Mr/Mrs/Miss/Ms/Other ……

First Name/s ……

Surname ……

Address ……..

…….

…….

…….

Post Code ……

CONTACT DETAILS

Telephone: Home …….

Work …….

Mobile ……..

Fax: …….

E-mail: …….

Are you a: Patient ☐
Parent/Relative ☐
Health care professional ☐
Association ☐

Other (Please state) …….

Occupation …….

Ethnic Origin (optional) ……..

MEMBERSHIP REQUIRED: *(please tick)* ANNUAL ☐ LIFE ☐ ***(Annual £10.00 Life £100.00)***
(Please make your cheque payable to U.K.T.Society)

IF YOU ARE A PATIENT OR PARENT OF A PATIENT PLEASE COMPLETE THE SECTION BELOW.

Patient's first name/s …… Date of birth: …….. Male☐ Female☐

Type of thalassaemia: (e.g. Major, Intermedia, Haemoglobin H etc) ……

Hospital where treated: …….

Hospital address: ……

……

……

…… Consultant's Name: ……

Consultant's Telephone Number: …….

GP's Name: ……..

GP's Address: ……

……..

GP's Telephone Number: ……

BLOOD TRANSFUSED: Whole Washed Frozen Filtered (Please tick) ☐ ☐ ☐ ☐

CHELATION: Desferal Deferiprone Desferal & Deferiprone (Please tick) ☐ ☐ ☐

Transfusion Frequency: …….. Units received at each transfusion …… Blood Type: ……

OFFICE USE: DATE PAID …….. RECEIPT No ……. APPROVAL DATE ……...