Humanitarian Aid
Basic Patient Information Collection Form

Details of person completing this form on behalf of the patient (Parent or Referring Adult)					
Full name:	First name(s):				
	Family name:				
Telephone no.: *including country dialling code*					
Email address:					
Relationship to patient:					
Date form completed:	DD	MM	YY	Country:	
If the patient is 16 years of age or under:	*I hereby confirm that I am the parent or legal guardian of the child named below who is below the age of 16 years old and I hereby provide consent on their behalf that the IGA can process his/her personal data for the purpose of advocating on your behalf for ERT treatment.*				
Evidence of parenthood/guardianship attached:	*Please provide proof of your parenthood/guardianship* YES / NO				
Signature of parent/guardian:					

Patient details					
Full name of patient:	First name(s):				
	Family name:				
Full postal address of patient:	House/Building name or no.:				
	Street:				
	Town:				
	City:				
	State:				
	Postal code/zip code:				
	Country:				
Patient's telephone no.: *including country dialling code*					
Date of birth:	DD	MM	YY	Gender:	Male ☐ Female ☐
Gaucher Type	I ☐	II ☐	III ☐		

PLEASE ATTACH THE FORM THAT CONFIRMS DIAGNOSIS OF GAUCHER DISEASE WHEN RETURNING THIS TO THE IGA

Please return this completed form to the IGA office by email tanya@gaucheralliance.org. Thank you

International Gaucher Alliance, 8 Silver Street, Dursley, Gloucestershire, GL11 4ND, UK

BY COMPLETING THIS FORM YOU ARE GIVING THE IGA PERMISSION TO SHARE THE INFORMATION CONTAINED WITH OTHER PARTIES AND STAKEHOLDERS WHO MAY BE ABLE TO HELP YOUR SITUATION

Your details are safe with us – Privacy Statement:

We will always store your personal details securely. We will only use them to provide the service(s) that you have requested and communicate with you in the way(s) you have agreed to. Your details may also be used for analysis purposes, to help us provide the best possible service. We will not pass on your details to anyone else and we will only share them if required to do so by law.

<table>
<tr><th colspan="4">Physician details</th></tr>
<tr><td>Name of Physician:</td><td colspan="3"></td></tr>
<tr><td rowspan="7">Full postal address
of physician’s hospital:</td><td>House/Building name or no.:</td><td colspan="2"></td></tr>
<tr><td>Street:</td><td colspan="2"></td></tr>
<tr><td>Town:</td><td colspan="2"></td></tr>
<tr><td>City:</td><td colspan="2"></td></tr>
<tr><td>State:</td><td colspan="2"></td></tr>
<tr><td>Postal code/zip code:</td><td colspan="2"></td></tr>
<tr><td>Country:</td><td colspan="2"></td></tr>
<tr><td>Physician’s telephone no.:
including country dialling code</td><td></td><td>Physician’s fax no.:</td><td></td></tr>
<tr><td>Physician’s email address:</td><td colspan="3"></td></tr>
</table>