RETINA SOUTH AFRICA (NPO Number 003-184)
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Postnet Suite 75, Private Bag X10020, Edenvale,1610
Tel: 0860 595959 Fax:0866536392

MEMBERSHIP FORM

AUTHORISATION:

I, the person named in Section 1 below ("the Member"), in my personal capacity and/or in my capacity as the parent or legal guardian of the child named in Section 2 below ("my child"), wish to become a member of Retina South Africa (RSA). I authorise my doctor named in Section 4 below to give my medical details to RSA. I further authorise RSA to process my and/or my child/ren's personal, biometric and health information for the following purposes:

- The administration of the services RSA provides.
- The treatment and care of me and/or my child.
- The sharing of the information with researchers who RSA may appoint.
- The compilation of statistical information.
- The creation of a profile of South Africans or South African communities who may participate in future clinical trials.

Signature:	Date:

SECTION 1 (MEMBER) Over 18 years or parent

SA Citizen	Yes	No	If not (tick)		Permanent Residence						Work Permit		
Identity No./ Passport No.:													
First Name/s:													
Surname:													
Title:	Dr	Mr	Mrs	Ms	Prof	Date of Birth:							
Gender:	Male	Female	Maiden Name (if applicable):										
Ethnic Group:	Asian		Black		Coloured		Indian		White				

SECTION 2 (AFFECTED CHILD) Use extra page if needed

First Name/s:													
Surname:													
Date of Birth:							Relationship:		Son (male)			Daughter (female)	
Identity / Passport No.:													
Ethnic Group:	Asian		Black		Coloured		Indian		White				

SECTION 3 (FAMILY HISTORY/NAMES)

Paternal (father) Grandmother Maiden Surname:
Maternal (mother) Grandmother Maiden Surname:
Mother Maiden Surname:

SECTION 4 (OPHTHALMOLOGIST/EYE Specialist)

Ophthalmologist's Name:		Tel:	
Hospital or state patient:	Yes	No	Hospital file number
If yes, hospital name:			

SECTION 5 (CONTACT INFORMATION)

Residential Address:					
	City:		Postal Code:		
Postal Address (if different):					
	City:		Postal Code:		
Home Tel:			Work Tel:		
Cell:					
email:					
Next of Kin:			Contact No.		
Province:	Eastern Cape	Free State	Gauteng	KZN	Limpopo
	Mpumalanga	North West	Northern Cape	Western Cape	SADC Country

SECTION 6 (AFFECTED FAMILY MEMBERS) Use extra page if needed

Are any of your family members affected	Yes	No

AUTHORISATION: By my signature of this Patient Registration Form I confirm that I have obtained the permission of the affected family members below to provide their personal information to Retina South Africa and for Retina South Africa to contact them, if required.

Name and Surname:	Date of Birth:	Relationship:	Contact Number:

SECTION 7 (Medical details)

Do we have a confirmation of your/your child's diagnosis:		Yes	No
Have you or your family had genetic counselling		Yes	No
If yes, name of genetic counsellor?			
Has your/your child's BLOOD or SALIVA been taken	NO	YES blood	YES saliva
Name or describe your/ your child's eye problem:			

FOR OFFICE USE

Application Date:			Membership No:				Classification:	
Retina	EC	GAU	KZN	NAT	NG	WC	Other	