

APPLICATION FORM**SECTION A: BIODATA**

1. Name:
2. Age: Date of Birth:
3. Sex: M F
4. Address:
5. Mobile number: WhatsApp number:
6. Email Address:
7. Occupation:
8. Company where employed:
Position held at company: Income per month:
If private business owner, then sales turn over per month:
9. If Student, name of school being attended:

SECTION B: MEDICAL HISTORY

1. When were you diagnosed of Myasthenia Gravis (MG)?
2. What type of Myasthenia Gravis (MG) were you diagnosed with?
AChR type AtiMuSK type Unknown
3. Name of hospital where diagnosis was made:
4. Name of diagnosing/treating physician:
5. What medication are you on? List them all.



SECTION C: TO BE COMPLETED BY THE ATTENDING PHYSICIAN

1. Name of attending physician:

2. Mobile number: WhatsApp number:

3. Email address:

4. Name of Neurologist in-charge (Consultant/Specialist):

5. Does the patient attend reviews regularly?

Yes No

6. Is the patient compliant with medication?

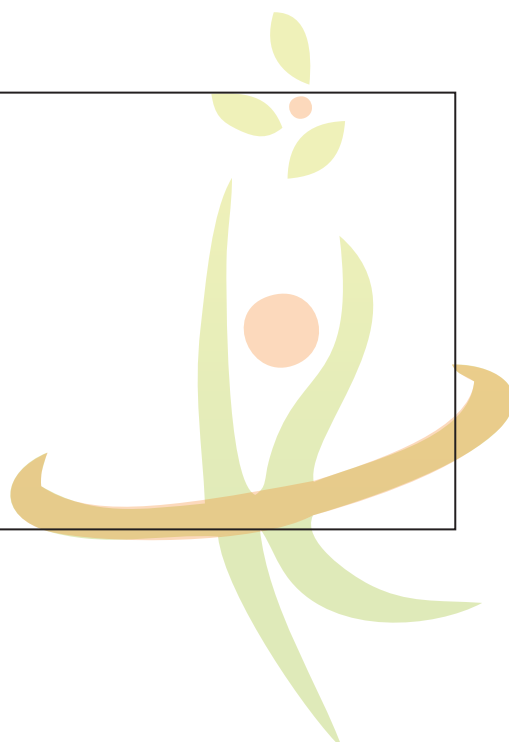
Yes No Unknown

7. Other comments about the patient

8. Signature:

Date:

SECTION D: FOR OFFICIAL USE



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