

NODSS - AUSTRALIA



NODSS - Narcolepsy & Overwhelming Daytime Sleep Society of Australia

ABN 74 098 031 595

PO Box 100
Rosanna Vic 3084
Australia

Phone 03 9761 9767
03 9432 9669
Fax 03 9761 9727
03 9432 9758

Email info@nodss.org.au
website www.nodss.org.au

MEMBERSHIP APPLICATION FORM

(Confidential)

Office use only
Receipt No. _____
Date rec'd _____

Dr/Mr/Mrs/Miss/Ms

Surname _____ **First Names** _____

(Please use BLOCK LETTERS)

Address _____

State _____ **Postcode** _____ **Country** _____ **Phone** _____

Date of Birth _____ **Occupation** _____ **Fax** _____

email _____

I would like to become a member of the Narcolepsy and Overwhelming Daytime Sleep Society of Australia. If this application is approved, I agree to abide by the rules of the Society for the time being in force.

Signed _____ **Date** _____

I do/do not wish to go on the NODSS phone contact list - i.e.. being available to other members for contact.

I do/do not wish to be contacted for Sleep Research purposes (see WHAT IS NODSS? information brochure)

Annual Membership of NODSS: \$33 Single or Family; \$22 Student or Concession. **All prices include GST.**

(Students, Pensioners or any Person unable to pay this amount please let us know) Mem.Fees \$ _____

Cost of M.J.Utley book on NARCOLEPSY, recommended reading (\$10.00 inc. post) No. _____ \$ _____

Cost of Handbook NODSS Guide to Sleep Disorders (\$10.00 inc. post) No. _____ \$ _____

Personal Experiences 2 (\$5.00 inc. post) No. _____ \$ _____

Pill Box Timer @\$10.00 inc. GST & post) No. _____ \$ _____

Note: Donations of \$2.00 and over are tax deductible Donation \$ _____

I enclose a cheque/money order/cash (payable to NODSS) TOTAL \$ _____

Please tick Box if you require a Tax invoice and receipt

Note on Privacy.

The following information is requested so that NODSS can update its sleep disorder database. This information is seen only by the Mail Secretary, the Counsellor and the Records Officer. Statistical information with NO reference to member's names may be given for research purposes. If you have agreed to take part in scientific research you will still be contacted for your approval before your name is given to any researcher.

Please answer all questions: if unsure of answer please put approximate date or figure.

1. My interest in NODSS is (please tick)

I have a diagnosed sleep disorder

I suspect I have a sleep disorder

I have a relative with a diagnosed sleep disorder Relationship _____

I have a relative with a suspected sleep disorder Relationship _____

Professional Interest Thank you - your application is now complete.

Other _____

2. How long have you had symptoms? _____ If diagnosed, when? _____

3. How many doctors, including family doctor and diagnosing specialist, did you consult before diagnosis? _____

Please turn over

4. (a) Do you have diagnosed narcolepsy? Yes/No sleep apnoea? Yes/No

(b) Other diagnosed sleep disorder _____

5. Do you suffer the following? (please tick)

Excessive daytime sleepiness (EDS)	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>
Cataplexy	<input type="checkbox"/>	Sleep Paralysis	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	Vivid Dreams/Nightmares	<input type="checkbox"/>
Disrupted Night Sleep	<input type="checkbox"/>	Automatic Behaviour	<input type="checkbox"/>
Sleep Apnoea	<input type="checkbox"/>	Restless legs syndrome	<input type="checkbox"/>
Other _____		Periodic Limb Movement Disorder	<input type="checkbox"/>

6. Are you currently taking medication? Yes/No 6a. Using CPAP Yes/No dental appliance Yes/No

If yes, type and present dosage/usage: _____

7. How long have you been on this treatment? _____

8. Do you feel the treatment(s) has/have side effects (physical or psychological on you)? Yes/No

If yes, please list: _____

9. Have you changed your medication/treatment since diagnosis? Yes/No

If yes, state type and reason for change: _____

10. Would you recommend your General Practitioner? Yes/No

If yes, list name and address _____

11. Would you commend your diagnosing or present specialist Yes/No Type of specialist _____

If yes, list name and address _____

12. Do you feel your symptoms have reduced (or will reduce) the quality of your life? (please tick)

No A Little Considerably Very Much

13. If ONE of your symptoms could be miraculously cured, which one would you nominate?

14. Any other comments you would like to make? _____

Please mail to:
NODSS - Australia
PO Box 100
Rosanna Vic 3084
Australia

All donations \$2.00 and over tax-deductible