

Statement of Confidentiality: The information provided here is covered by the Data Protection Act and is for analytical and statistical research only and will not be shared with any other organisation.

Thank you for your help with our continued research.

Questionnaire
Name:
Address:
Postcode:
Email:
Telephone:
Relationship to Patient:
If you are completing this form on behalf of a patient please complete the following:
PATIENT DETAILS
Name:
Address:
Postcode:
Email:
Telephone:
<input type="checkbox"/> Tick here if you do not wish to be included in our mailing list.
Age: or Age Group: 0-14 15-24 25-60 61and over
Type of Histiocytosis:
Place of Treatment:

Name of Consultant:

Name of GP:

Address of GP:

Name of Dentist:
(if applicable)

Address of Dentist:
(if applicable)

Any other details you feel are relevant and would like to share:

When complete please email this form to Histio@Histiouk.org or send by post to:
Histio UK, Litton House, Saville Road Peterborough PE3 7PR.
Thank you for your participation.