Register on line at http://trisomy.org/form-membership-families/ SOFT **Support Organization for Trisomy 18, 13 and Related Disorders**

PARENT Name(s):_____

Mail Address: _____
Street City/Town State/Province Country Zip Code

Phone: (_____)_____ **E-mail**: _____

CHILD's Name: _____ **Sex**: (circle) M **F** **Date of Birth**: _____ **Date of Death**: _____

Cause of Death: _____

Affected Chromosome: 18 ☐ 13 ☐ Other: _____ (please specify)

Diagnosis: Full ☐ Mosaic ☐ Partial ☐ Translocation: _____ (please specify)

Other (please explain): _____

Child Health inquires: Providing SOFT with information about your child's **growth**, **immunizations** and **surgeries** is **optional.** This data might be of help for other families or for medical studies concerning our children. We would appreciate your input.

Growth: (Circle all that apply)
How is (or was) your child fed? **Tube Bottle Breast Cup Spoon other** Is (or was) your child able to self-feed? **YES NO With Help**

Birth weight: _____ (lbs/oz) **Birth Length:** _____ (inches)

Current/Last Weight: _____(lbs/oz) **Current/Last Length:** _____ **(inches)** **Current/Last date:** _____
If your child is no longer living please provide last known measurements and at what approximate age:_____

Immunizations: (circle answer where applies)
1.) Is your child or, if no longer living, was your child up-to-date with your state recommended immunizations? **YES NO Don't Know**
2.) Is (or was) your child on a delayed immunization schedule? **YES NO**
3.) Did you decline (refuse) any immunizations? **NO ALL SOME** (explain) _____
4.) Did your child receive the Synagis series for prevention of RSV? **YES NO Declined shot series**
5.) Does (or did) your child receive a seasonal flu vaccine every year? **YES NO Declined vaccine**
7.) If your child had a **reaction** to any vaccines/shots, please explain which immunization and reaction. _____

Surgical Information: SOFT maintains a surgery database to help families needing information. When reporting surgeries using a mailed paper form, use a separate page if more entries are needed. When reporting by Web, if additional space is needed, please write the others on the back of this form.

#	Date	Name of Surgery	Name, City, State of Hospital	Name of Doctor	Successful ?
1					
2					

SOFT Survey: (Circle answer which applies)
1.) How did you learn about SOFT? **Health Care Provider Another SOFT parent WEB site Other** (explain) _____
2.) Barb VanHerreweghe is the contact person for states that do not have a local chapter chair. Have you been in contact with Barb? **YES NO**
3.) Have you been in contact with someone from your state or nearby state that is your state's local SOFT chapter chair? **YES NO**

DONATIONS: If you wish to make a donation to SOFT, please enter the amount here: $_____

If the donation is for a special purpose, please state that here:_____

Circle Card Name: VISA MasterCard Card #_____ Exp. Date:_____/_____
month/year

Last 3 digits on back of the card: _____ (security code)

Signature:_____ Date:_____

If donating by check, please enclose the check!

PLEASE SEND THIS FORM to:
SOFT Membership Committee, c/o Barb VanHerreweghe, 2982 South Union St., Rochester, NY 14624
We assume that your name may be shared with other SOFT members (only) unless you specify otherwise.

SEE SOFT'S HOMEPAGE FOR INFORMATION ABOUT SOFT, CONTACTS, MEDICAL AND FAMILY INFORMATION, AND THE NEXT CONFERENCE:
http://www.trisomy.org (800) 716-SOFT (7638)