





## REGISTER YOUR INTEREST IN DEMENTIA RESEARCH TODAY

### Please read the following instructions carefully.

On this registration form, you will find the basic information needed to register either yourself **or** someone else for the service.

### You can only complete this form for one person.

After completing and sending in this form, a welcome letter or email (and welcome booklet) should arrive within 21 days.

Your welcome booklet will include guidance on how to manage your account, where you can update your or the volunteer's information. If you do not wish

Alzheimer Scotland  
**0808 808 3000**

Open 24 hours a day,  
7 days a week.  
(Scotland)

Calls to Alzheimer Scotland are free. Calls to Alzheimer's Research UK and Alzheimer's Society cost no more than a national call from any type of phone or provider and calls are included in any free call packages on landlines and mobiles.

Once your account has been set up, you can improve the likelihood of matching with a suitable study by answering a more detailed set of questions. If you have provided us with an email address you will be able to do this online, or alternatively you can call one of the helplines to update your account.

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Alzheimer's Research UK  
**0300 111 5 111**

Mon - Fri: 9am - 5pm  
(UK wide)

Alzheimer's Society  
**0300 222 1122**

Mon - Wed: 9am - 8pm  
Thurs - Fri: 9am - 5pm  
Sat - Sun: 10am - 4pm  
(England, Wales & Northern Ireland)

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MOISTEN HERE AND STICK PAGE 6 TO THIS PAGE

**PLEASE ONLY COMPLETE THIS PAGE IF YOU ARE REGISTERING SOMEBODY ELSE FOR THE SERVICE**

If you are signing up yourself as a volunteer, you **do not** need to complete this page. Please go to pages 4 and 5.

**YOUR INFORMATION AS A REPRESENTATIVE**

Although you are signing up someone else, we still need **your** information on this page. You can enter the details of the person you are registering on the next two pages.

You **MUST** answer **ALL** questions to complete a registration. Before completing this section, please read the declaration text B carefully on page 6.

**TEAR ALONG PERFORATION AND KEEP PAGES 1 AND 2**

TITLE (Dr, Mr, Mrs etc.)  TOWN / CITY   
FIRST NAME  COUNTY   
SURNAME  POSTCODE   
PHONE   
DOB (DD/MM/YY)   
GENDER Male  Female  Not Specified   
EMAIL (Please leave blank if you do not have one)   
Do you have the same address as the volunteer? YES  NO   
Should communications to the volunteer be sent through you? YES  NO   
If you ticked no - please add **your** address below  
HOME ADDRESS   
Should communications be sent directly to the volunteer? YES  NO   
If you tick 'yes' to both of the above, both you and the volunteer will receive a welcome booklet.

**MOISTEN HERE AND STICK PAGE 6 TO THIS PAGE**

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**INFORMATION ABOUT THE VOLUNTEER**

On the next two pages, please enter either:

- Your details (if you are signing yourself up as a volunteer) **OR**
- The volunteer's details (if you are signing up someone else).

Before completing this section, please read the declaration text carefully (either A or B) on page 6. You **MUST** answer **ALL** the questions on pages 4 and 5.

TITLE (Dr, Mr, Mrs etc.)   
VOLUNTEER'S FIRST NAME   
VOLUNTEER'S SURNAME   
TOWN / CITY   
COUNTY   
POSTCODE   
PHONE   
DOB (DD/MM/YY)   
GENDER Male  Female  Not Specified   
HOME ADDRESS   
TOWN / CITY   
COUNTY   
POSTCODE   
PHONE   
EMAIL (Please leave blank if you do not have one)   
If the volunteer registering as someone who has a diagnosis or is being investigated for a dementia related disorder?  
YES  NO   
If yes, what is the volunteer's diagnosis?  
ALZHEIMER'S DISEASE   
VASCULAR DEMENTIA   
MILD COGNITIVE IMPAIRMENT (MCI)   
MIXED DEMENTIA   
DEMENTIA WITH LEWY BODIES   
FRONTOTEMPORAL DEMENTIA (FTD)   
ALCOHOL-RELATED DEMENTIA (including Wernicke-Korsakoff syndrome (WKS))   
DEMENTIA IN PARKINSON'S DISEASE   
DEMENTIA IN HUNTINGTON'S DISEASE   
OTHER DEMENTIAS   
NOT AWARE OF SPECIFIC DIAGNOSIS   
Is the volunteer currently taking any of these memory medications?  
DONEPEZIL HYDROCHLORIDE (ARICEPT)   
RIVASTIGMINE (EXELON)   
MEMANTINE HYDROCHLORIDE (EBIXA)   
GALANTAMINE (REMINYL)   
NONE OF THE ABOVE   
Does the volunteer have a carer / someone that knows them well, and who helps support them with their dementia or memory difficulties?  
YES  NO   
Does the volunteer have any disabilities?  
DEAFNESS   
BLINDNESS   
MOBILITY   
LEARNING OR INTELLECTUAL DISABILITY   
COMMUNICATION DIFFICULTIES   
NONE OF THE ABOVE   
ANY OTHER DISABILITIES (please specify)   
How would the volunteer like to be kept up-to-date with research opportunities?  
Please tick all that apply  
EMAIL  PHONE  POST  TEXT   
Would you / they like to receive a regular newsletter?  
YES  NO   
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Does the volunteer have any other medical conditions?

DOWN'S SYNDROME   
SLEEP DISORDERS   
CANCER   
SIGNIFICANT CARDIAC PROBLEMS   
STROKE   
HIGH BLOOD PRESSURE   
DIABETES   
DEPRESSION   
OTHER MENTAL HEALTH ISSUES   
NONE OF THE ABOVE   
OTHER MEDICAL CONDITION (please specify)   
How did you find out about Join Dementia Research?  
MEMORY SERVICE   
EXHIBITION/EVENT   
CHARITY   
OTHER (please specify)   
Please provide the name of the hospital/trust/memory service/event where you received this form:   
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**PLEASE MAKE SURE  
YOU READ THIS  
SECTION CAREFULLY**

Please read the declaration text that applies to you (A or B) on page 6 carefully. If you do not sign in the box below to confirm your agreement to the terms and conditions, you will not be considered for studies.

I HAVE READ, UNDERSTAND  
AND AGREE TO THE TERMS &  
CONDITIONS ON PAGE 6.

Signature

Today's Date   
DD / MM / YYYY

MOISTEN HERE, FOLD IN HALF AND SEAL TO PAGE 4

MOISTEN HERE AND STICK PAGE 6 TO THIS PAGE

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