

To: The Coeliac Society of Western Australia, Inc.:

Patient Name: _____

Address: _____

Phone No: _____ Date of Birth: _____

Our records show this patient has:-

- Coeliac Disease and requires a gluten free diet
- Dermatitis Herpetiformis and requires a gluten free diet
- Requires a gluten free diet for an alternative medical reason

This has been diagnosed by:-

- Blood test
- Endoscopy and biopsy
- Other _____

Other relevant information/comments:-

I would be grateful if you would consider them for membership of the Society.

Name of Registered Medical Practitioner: _____

Signature: _____

Surgery Name & Address: _____

Date: _____