MS Register Incidence Form

SERIAL NUMBER (OFFICE USE ONLY)	

* Where this form is completed

** All dates must be in the format DD/MM/YYYY

CHI Number	0

Is the patient under 16 years old?	
Has the patient declined MS Nurse support?	

Data Collection	
Hospital/Centre*	
Competed by	

Personal Details	
Surname	
Forename	
Patient Postcode	
Gender	
Ethnicity	
GP Name	
GP Address	
Country of Birth	
If other country, please specify	
City/Town of Birth	
Employment status at time of diagnosis	
If sick/disabled, is this a result of MS?	
If employed/self employed; regular/average number of hrs/wk	
Domestic/Marital status at time of diagnosis	
If other marital status, please specify	
Does any 1st degree family member have a diagnosis of MS?	

Additional Information	

Have you discussed the opportunity of the Future MS research with your patient?
www.future-ms.org

Investigations	
Was a brain MRI carried out?	
Was a spinal cord MRI carried out?	
Was a lumbar puncture carried out?	
Was oligoclonal bands present?	

Referral to CONFIRMED Diagnosis	
Date of 1st onset of symptoms**	
Date of initial referral to Neurology**	
Date seen in Neurology**	
Date referred to MS Specialist Neurologist**	
Who confirmed diagnosis of MS?	
Diagnosing Hospital	
Date of confirmed diagnosis**	
Type of MS	
Was the patient offered DMTs?	

First MS Contacts following confirmed diagnosis of MS	
N.B. The following dates MUST be following confirmed diagnosis	
Date of referral to MS Nurse**	
Date referral received by MS Nurse**	
Date of 1st contact with MS Nurse**	
Type of Contact with MS Nurse	

Is this an exception?	
Reason for breach of standard?	

Validation status for this record:	