Sample Email/Fax Template for Clinical Trials

Date ______________

Clinical Coordinator Name ______________________________

ALS Clinic Name ______________________________

City, State, Country ______________________________

Dear______________________________ [Clinical Coordinator Name],

I have a confirmed diagnosis of ALS and am interested in screening for the
______________________________ [Trial Name] trial at your research center. I know your time is valuable, so I have included my health information that is typically requested in ALS trials with the hope of being pre-screened quickly and considered a good candidate for the trial. Please let me know if any additional information is required, including specific medical records, lab testing, doctor's notes, etc. and I will ensure that you receive this from me or my neurologist's in-office team.

If I do not qualify for this trial, could you or another member of your research team reach out to me and discuss other trials and expanded access opportunities you are working on?

Thank you for your time and consideration,
______________________________[Your Name]

Name: ______________________________
Date of birth: ______________________________
Address: ______________________________
City, State, Zip: ______________________________
Phone: ______________________________
Email: ______________________________
Neurologist: ______________________________
Clinic: ______________________________
Address: ______________________________
City, State, Zip: ______________________________
Phone: ______________________________
Fax: ______________________________
Email: ______________________________

I AM ALS

Onset of symptoms associated with ALS occurred (month/year) Date:

____

Diagnosis Date: ___________________________

Part of the body where symptoms first occurred:_______________________________

ALSFRS-R Most recent Score and Date: _____________________

FVC/SVC scores/date: ______________________

Currently using feeding tube: ▢ Yes ▢ No

Ability to safely swallow pills and liquids: ▢ Yes ▢ No

Family history of ALS: ▢ Yes ▢ No ▢ Unknown

Genetic testing result and name of lab if known:

____

Current ALS medications: Riluzole: ▢ Yes ▢ No

Start date

____

Radicava: ▢ Yes ▢ No

Start date

____

Nuedexta: ▢ Yes ▢ No

Start date

____

Other current medications/supplements:

____

____

Dependence on invasive mechanical ventilation: ▢ Yes ▢ No