Registration Form (RFNT)

Date: ____________________

Personal details:

Name: ____________________

DOB: ____________________

Medical issues/Allergies ____________________

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First Language ____________________

Address: ____________________

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Telephone: ____________________ Email: ____________________

GP name and phone number

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I agree my details to be shared with my GP ☐

We can contact you to arrange appointments: by email ☐ by phone ☐ by post ☐

We can contact you to send all relevant documents: by email ☐ by post ☐

Please return the completed form by post to:

Sensory Space
Unit 5
Dublin Road
Drogheda
Co. Louth A92 XE86

Alternatively, scan and email to: **info@sensoryspace.ie**

If you have any queries, please phone: **041 980 3307**