NATIONAL REYE'S SYNDROME FOUNDATION

Reporting a Case of Reye's Syndrome

PERSON

Date of Reye's Syndrome Occurrence_____ Age at Occurrence_____
Legal Name at Time of Occurrence, of Person Having Reye's

_____

Male_____ Female_____
Geographic Location at Time of Reye's Syndrome Occurrence:
Address/Street_____City_____County_____
State_____ Zip Code_____ Country_____

HISTORY

Precedent Illness and/or Symptoms

_____
_____

Was Medication Given? Yes_____ No_____
Was Aspirin Given? Yes_____ No_____
Other? Yes_____ No_____
Specify_____
Doctor and Hospital Where Treated (Include City & State/Province)

_____
Course of Reye's Syndrome Illness and Treatment

_____
Additional Comments

_____

OUTCOME

Outcome Survived_____ Present Age_____
Deceased_____ Date_____
Survived With Residual Handicapping Condition (Please Specify)

_____

_____

INFORMATION

Current Information of Survivor or Person Reporting Case:
Name_____
Address / Street_____City_____ County _____
State_____ Zip Code_____ Country_____
E-mail_____
This Report Has Been Completed By_____
Relationship To Person Having Reye's_____

Thank you for taking the time to complete this report. All information kept confidential within the foundation.
Mail this form to: NRSF, PO Box 829, Bryan, OH 43506-0829 USA or FAX 1-419-636-9897.