(Please save the PDF form after completing it)

PFS Suicide Support Program

If a loved one who suffered from post-finasteride syndrome took his own life and you would like to connect with family members of other PFS patients who took their own lives, please complete this form and email it to social@pfsfoundation.org

1. My name _____

2. Name of PFS patient who took his own life _____

3. Approximate date of suicide _____

4. My relationship to PFS patient who took his own life

◯ spouse ◯ parent ◯ sibling
◯ significant other ◯ child
◯ other (please specify) _____

5. My location

City and state (if living in the U.S.) _____

City and country (if living outside the U.S.) _____

6. Location of PFS patient who took his own life

City and state (if in the U.S.) _____

City and country (if outside the U.S.) _____

7. Contact info

I wish to be contacted via (select as many as apply):

Email: ☐ My email address is: _____

Telephone: ☐ My phone number is: _____

Skype: ☐ My Skype address is: _____

8. Date (month) _____ (day) ____ (year) _____

CONFIDENTIALITY

I understand that, upon submitting this form to the PFS Foundation, I agree to allow the foundation to distribute the information contained herein to other immediate relatives of PFS patients who have taken their own lives, as directed above. The foundation will not publish or otherwise disseminate any personally identifiable information without my written consent.

_____

Signature

If you have any questions, please contact:

Philip Roberts
Patient Manager
PFS Foundation
proberts@pfsfoundation.org
(856)425-6046

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