Patient Story Submission Form

Disclaimer: The purpose of collecting these stories is for the use in SRS activities, i.e. website, film, brochures, posters, published literature materials, newsletters, philanthropy materials and other venues as appropriate. In addition, these stories could be used in SRS publications, in public service ads, or in patient advocacy activities. Not all stories submitted will be accepted and posted on the website or in other forms of media. SRS will not accept any patient stories that have already been copyrighted, told through the form of newspapers, magazines or with the assistance of hospital websites etc.

Patient:

Name: ________________________________
Address: ________________________________
City/State/Zip: ________________________________
Condition: ________________________________
Age: ________________________________
Occupation: ________________________________

Orthopaedic Surgeon:

Name: ________________________________
Address: ________________________________
City/State/Zip: ________________________________
Phone: ________________________________
Fax: ________________________________
Email: ________________________________

Please submit attached to your submission form the following:

___ Your story written in digital format
___ Before and after pictures
___ Any other materials that help illustrate your story, video, poetry, photographs etc.
___ Vignette Release Form

Optional questions to consider when writing your story:

How did you find out you had scoliosis?
What was your treatment plan?
How has the outcome of your treatment affected your life?
What do you wish you knew about scoliosis before you were diagnosed?

Optional:

Ethnic Diversity: ________________________________
Gender: ________________________________

Remember to include any extra pages of description, videos, background, photos, etc.