Version 1.5

Second questionnaire

Re: Patients with spinal muscular atrophy who were born between January 2016 and December 2020

Please complete the information below.

Your institution anonymization number:

Patient birth month and year:

Sex: Male Female

Type of spinal muscular atrophy: type 1 type 2 other ( )

Was genetic testing used?

No Yes

(Results: copy number of *SMN1* and S*MN2*; examining institution)

Was tracheostomy with invasive positive-pressure ventilation used? No Yes
Was respiratory support needed? No Yes

Please circle ○ if the therapy was used:

Spinraza® (Starting year and month)

Zolgensma® (Starting year and month)

Evrysdi® (Starting year and month)

Present status:

Signature:

We very much appreciate your support.