Medical Information

Date of Application: _____ Application Completed By: _____

Date of Diagnosis: _____ Primary Cancer Diagnosis: _____

Stage of Cancer _____ ( ) New Diagnosis ( ) Recurrence

In active treatment? ( ) YES ( ) No

If the answer to whether the patient is in active treatment is YES, please indicate type of treatment

Circle ALL that apply

Chemotherapy	Radiation	Clinical Trial	Hormonal	Surgery	Palliative Care
Bone Marrow/Stem Cell Transplant		Complementary/Alternative			

If the answer to whether the patient is in active treatment is NO, is post treatment follow-up needed? ( ) YES ( ) No

If the answer to whether post treatment follow-up is needed is YES, please indicate type of follow-up:
( ) Yearly ( ) Every six months ( ) Other _____

Name of Oncology MD (please print) _____

MD License # _____ Hospital/Clinic _____

Address: _____
Street Address

_____
City State ZIP Code

Daytime Phone: _____ Fax Phone: _____

Name/Title of Oncology RN, if completing section: _____

ONLY if completing this section, RN License #: _____

_____
Signature of Oncologist (MD)/Oncology Nurse (RN) completing this section

Please submit to:
#teamcorrie Cancer Foundation
145 Parker Drive
El Dorado, AR 71730