CANCERcare

APPLICATION FOR FINANCIAL ASSISTANCE

MEDICAL INFORMATION
THIS SECTION MUST BE COMPLETED BY YOUR ONCOLOGY NURSE, DOCTOR, SOCIAL WORKER OR HOSPITAL ACS PATIENT NAVIGATOR ONLY

Primary cancer _____ Current Stage: _____

☐ New Diagnosis Date: _____

☐ Recurrence Date: _____

Is the patient in active treatment?

☐ Yes ☐ No

If not in active treatment, indicate frequency of follow-up:

☐ Yearly ☐ Every six months ☐ Other: _____

Please indicate type of treatment(s) received in the past twelve months:

☐ Chemotherapy ☐ Radiation ☐ Surgery

☐ Hormonal ☐ Palliative Care ☐ Bone Marrow/Stem Cell Transplant

☐ Cart-T ☐ Immunotherapy ☐ Targeted therapy

Has the patient participated in a clinical trial?

☐ Yes ☐ No Name of the clinical trial: _____

Has the patient been tested for biomarkers?

☐ Yes ☐ No Name of the biomarkers: _____

HEALTH CARE PROFESSIONAL INFORMATION (please print)

MD Name: _____ Hospital/Clinic: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

NAME AND TITLE OF PERSON COMPLETING THIS SECTION, IF DIFFERENT THAN ABOVE (please print)

Phone: _____ Email Address: _____

Your relationship to person applying: ☐ Doctor ☐ Nurse ☐ Social Worker ☐ Hospital Patient Navigator

Signature of Medical Professional: _____ Date: _____