

Important

This form to be completed by a member of the oncology treatment team such as a social worker, nurse, navigator or doctor and returned to Angel Foundation by email at grants@mnangel.org or by fax to **(612) 338-3018**. If you need assistance with the Medical Information Form or have questions, please contact Angel Foundation.

Patient Information

First Name _____ Middle Initial _____ Last Name _____
Birthdate (MM/DD/YYYY) ____ / ____ / ____ County _____
Street Address _____ Apt _____
City _____ State _____ Zip _____
Phone _____ Email _____

Medical Information

Type of Cancer Diagnosis _____ Cancer stage _____
Clinic/Hospital Name _____ City _____
Oncologist Name _____

Current Treatment (please check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Chemotherapy | Date of last (or next) treatment _____ |
| <input type="checkbox"/> Clinical trials | Date of last (or next) treatment _____ |
| <input type="checkbox"/> Hormone therapy | Date of last (or next) treatment _____ |
| <input type="checkbox"/> Hospice | Date entered _____ |
| <input type="checkbox"/> Immunotherapy | Date of last (or next) treatment _____ |
| <input type="checkbox"/> Palliative care | Date entered _____ |
| <input type="checkbox"/> Radiation | Date of last (or next) treatment _____ |
| <input type="checkbox"/> Surgery | Date of surgery _____ |
| Will the patient's recovery from surgery take at least four weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> Transplant | Date of transplant _____ |
| <input type="checkbox"/> Other | Date and type _____ |

I attest the patient has cancer and is currently being treated as stated above.

Name (please print)

Title

Email

Phone

Signature

Date