Medical Information Form

Help when cancer strikes angel foundation

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 IInformation

Type of Cancer Diagnosis _____ Cancer Stage _____

Clinic/Hospital Name _____ City _____

Oncologist Name _____

Current Treatment (please check all that apply): _____

- ☐ Chemotherapy — Date of last (or next) treatment _____
- ☐ Clinical trials — Date of last (or next) treatment _____
- ☐ Hormone therapy — Date of last (or next) treatment _____
- ☐ Hospice — Date entered _____
- ☐ Immunotherapy — Date of last (or next) treatment _____
- ☐ Palliative care — Date entered _____
- ☐ Radiation — Date of last (or next) treatment _____
- ☐ Surgery — Date of surgery _____
- ☐ Will the patient's recovery from surgery take at least four weeks? ☐ Yes ☐ No
- ☐ Transplant — Date oftransplant _____
- ☐ 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 _____