Medical Information Form

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™.

Health Care Professional Validation Code:

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 of transplant ______
- ☐ 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