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.

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 _____ Stage _____

Current Treatment (please check all that apply):

- ☐ Chemotherapy — Date of last (or next) treatment _____
- ☐ Radiation — Date of last (or next) treatment _____
- ☐ Immunotherapy — Date of last (or next) treatment _____
- ☐ Hormone Therapy — Date of last (or next) treatment _____
- ☐ Bone Marrow Transplant — Date of transplant _____
- ☐ Surgery — Date of surgery _____
  - Will the patient's recovery from surgery take at least four weeks? ☐ Yes ☐ No
- ☐ Palliative Care — Date entered _____
- ☐ Hospice — Date entered _____
- ☐ Other — Date and type _____

Clinic Information

Clinic Name _____ County _____

Street Address _____ Ste _____

City _____ State _____ Zip _____

Oncologist _____

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

_____ _____

Name (please print) Title

_____ _____

Signature Date