

Patient Name: Last: _____ First: _____ Middle: _____ Suffix: _____

Survivorship Program Clinic Intake Form

Demographics

1. Date form completed: _____ \ _____ \ _____
Month Day Year
2. Name (legal) : _____
Last First Middle Suffix
3. Preferred name/nickname (if any): _____
4. Prior names during treatment: last: _____ first: _____
5. DOB: _____ \ _____ \ _____
Month Day Year
6. Gender: Male Female
7. Mailing Address: _____
City: _____ State: _____ ZIP: _____
8. Email address: _____
9. Phone: home: _____ - _____ - _____ work: _____ - _____ - _____ cell: _____ - _____ - _____
10. Next of Kin/Emergency Contact: : _____
Last First Middle
Mailing Address: _____
City: _____ State: _____ ZIP: _____ Relationship: _____
Phone: (____) _____ - _____ (____) _____ - _____ (____) _____ - _____
Home Work Cell

Disease Information

11. Diagnosis: _____

12. Date of diagnosis: _____ \ _____
Month Year
13. What was the stage of your disease when you started your last treatment? _____ Don't know
14. Treatment (check all that apply):
Chemotherapy: Yes No
Radiation: Yes No
Surgery: Yes No
Immunotherapy (Interferon or Cancer Vaccines): Yes No
Biological Therapy (Gleevec, Iressa, Tarceva, Herceptin): Yes No
Bone Marrow Transplant: Yes No
Peripheral Blood Stem Cell Transplant: Yes No
Other: _____ Yes No
16. Have you been previously treated at the University of Washington Medical Center or SCCA? Yes No

Patient Name: Last: _____ First: _____ Middle: _____ Suffix: _____

Providers/Clinics

16. Treating oncologist:

Last: _____ First: _____

Mailing Address: _____ Phone: _____ - _____ - _____

City: _____ State: _____ ZIP: _____ Fax: _____ - _____ - _____

Last visit date with treating oncologist: _____ \ _____ \ _____

17. Primary care provider:

Last: _____ First: _____

Mailing Address: _____ Phone: _____ - _____ - _____

City: _____ State: _____ ZIP: _____ Fax: _____ - _____ - _____

18. Surgeon (if applicable):

Last: _____ First: _____

Mailing Address: _____ Phone: _____ - _____ - _____

City: _____ State: _____ ZIP: _____ Fax: _____ - _____ - _____

Type of MD (PCP, etc.) _____

19. Radiation Oncologist (if applicable):

Last: _____ First: _____

Mailing Address: _____ Phone: _____ - _____ - _____

City: _____ State: _____ ZIP: _____ Fax: _____ - _____ - _____

Type of MD (PCP, etc.) _____

20. Other physicians/specialty clinics treated at:

Name: _____

Mailing Address: _____ Phone: _____ - _____ - _____

City: _____ State: _____ ZIP: _____ Fax: _____ - _____ - _____

Type of MD (PCP, etc.) _____

Patient Name: Last: _____ **First:** _____ **Middle:** _____

SSN: _____ - _____ - _____

Insurance

21. Primary Insurance Company/HMO: _____ Policy / I.D # _____

Case Mgr / Contact _____

Mailing Address: _____ Phone: _____ - _____ - _____

City: _____ State: _____ ZIP: _____ Fax: _____ - _____ - _____

Group #: _____ Group Name: _____

Subscriber Information (for Primary Insurance)

Name _____ Relationship to Pt: _____

Mailing Address: _____ Phone: _____ - _____ - _____

City: _____ State: _____ ZIP: _____ Fax: _____ - _____ - _____

DOB: _____ \ _____ \ _____ SSN: _____ - _____ - _____ Gender: Male Female

Employer: _____

Employer Phone: _____ - _____ - _____ Employer Fax: _____ - _____ - _____

Employer Mailing Address: _____

City: _____ State: _____ ZIP: _____

22. Secondary Insurance Company/HMO: _____ Policy / I.D # _____

Case Mgr / Contact _____

Mailing Address: _____ Phone: _____ - _____ - _____

City: _____ State: _____ ZIP: _____ Fax: _____ - _____ - _____

Group #: _____ Group Name: _____

Subscriber Information (for Secondary Insurance)

Name _____ Relationship to Pt: _____

Mailing Address: _____ Phone: _____ - _____ - _____

City: _____ State: _____ ZIP: _____ Fax: _____ - _____ - _____

DOB: _____ \ _____ \ _____ SSN: _____ - _____ - _____ Gender: Male Female

Employer: _____

Employer Phone: _____ - _____ - _____ Employer Fax: _____ - _____ - _____

Employer Mailing Address: _____

City: _____ State: _____ ZIP: _____