Diagnosis Verification Form

Treatment Standard
For your Doctor to Complete

Instructions:
This form is to be completed, signed and dated by the applicant's CURRENT treating oncology provider, medical oncologist, radiation oncologist or cancer surgeon.

1. Please circle the treatment that your patient (our applicant) is currently receiving.

If treatment has not yet begun or has ended please circle which treatment was given/will most likely be given and list the date it ended/is planned to begin. *Please note if patient is receiving any of the options listed below for another diagnosis.

2. Fill in all other blanks with the requested information.

3. ***This must be completed and sent in along with the letter discussed on the previous page.***

Applicant's Name: _____

Date _____Applicant was diagnosed with _____cancer:

Is applicant currently in ACTIVE treatment for a _____ cancer diagnosis: Yes No

(Please note, RCCC does not recognize long term hormone modifiers alone, as ACTIVE treatment)

Please circle below what treatment the applicant is currently receiving (if patient has previously received chemotherapy please state start and end dates)**:**

Chemotherapy

- Yes; if yes, state chemotherapy currently being received _____
- No

Date treatment was last given if treatment is done: _____

Date treatment is planned to begin if not started yet: _____

Radiation

- Yes; if yes, state area(s) receiving the radiation currently _____
- No

Date treatment was last given if treatment is done: _____

Date treatment is planned to begin if not started yet: _____

Cancer Surgical Intervention

- Yes; if yes, state type of cancer surgical intervention _____
- No

Date surgery was done: _____

Date surgery is planned if not done yet: _____

Est. Surgical recovery period: _____

Date treatment was last given if treatment is done: _____

Date treatment is planned to begin if not started yet: _____

Oncology Provider: _____ Date: _____

Oncology Provider name printed: _____

Hospital or clinic name

Phone Number