Rock County Cancer Coalition
Diagnosis Verification Form

Caring | Community | Compassion

Treatment Standard For your *Doctor to Complete*

Applicant's Name: _____Date _____

Type of cancer Applicant was diagnosed with _____

Is applicant currently in treatment for a _____cancer diagnosis: **Yes** **No**

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: _____

Other_____

Oncology Provider Signature: _____ Date: _____

Oncology Provider name printed: _____

Hospital/Clinic Name_____

Phone Number_____

Form Updated Nov 8, 2021