waterfordplace Cancer Resource Center

Participant Information Form

Welcome to Waterford Place. Please take a few minutes to complete this confidential information form. Your personal information will only be used for registration and record keeping and is never shared with outside sources. This information provided here is used to help develop and recommend programs and to generate the funds that allows Waterford Place to continue to serve those impacted by cancer in the most effective ways possible.

Name *(Please Print):*		Today's Date:
Street Address:		City:
State:	Zip:	County:
Date of Birth:	Gender:	Email Address:
Preferred Phone Number: ☐Cell ☐Home		Can Waterford Place Leave a Message? ☐Yes ☐No
☐Permission to receive text reminders and notifications. If yes, please provide your cell provider:		
Emergency Contact Name:		Your Relationship to Emergency Contact:
Emergency Contact Phone Number:		Can Waterford Place Leave a Message? ☐Yes ☐No

Cancer Specific Information

Primary Cancer Type:	Cancer Stage: ☐ 0 ☐ I ☐ II ☐ III ☐ IV ☐ unknown
Approx. date of original cancer diagnosis:	Has cancer metastasized/spread from its original location? ☐ Yes ☐ No
Has cancer recurred? ☐ Yes ☐ No	If yes, date you learned of recurrence or metastasis:
Physician's Name *(Medical Oncologist, Radiation Oncologist or Surgeon):*	
Physician Location:	Physician Fax Number *(Optional):*
Did your physician or someone from their office refer you to Waterford Place? ☐ Yes ☐ No	

Current Cancer Treatment Information

(Check the boxes that best describe each)

Treatment Status
- ☐ Pre-treatment
- ☐ In Active Treatment
- ☐ Completed treatment (Date completed) _____
- ☐ Supportive or Palliative Care only

Current Treatment
- ☐ To Be Determined
- ☐ Watch and Wait
- ☐ Surgery
- ☐ Chemotherapy or Targeted Therapy
- ☐ Radiation Therapy
- ☐ Bone Marrow / Stem Cell Transplant
- ☐ Oral Hormones / Hormone Therapy
- ☐ Other _____

Race/Ethnicity	Medical Insurance Status	Your Primary Language
☐ White, Non-Hispanic/Latino ☐ Hispanic Latino ☐ Black/African-American ☐ American Indian/Alaskan Native ☐ Pacific Islander/Hawaiian Native ☐ Multi-Racial ☐ Asian ☐ Other	☐ Private Insurance ☐ Medicare ☐ Medicaid ☐ Uninsured	☐ English ☐ Spanish ☐ Other: _____

PLEASE TURN OVER TO COMPLETE ⟶

Family Information

Adult Family Member(s) Names *(Currently living with you)*	**Relationship**

Children Names *(Under the age of 18 and living with you)*	**DOB**	**Gender**

Please Check ALL the Areas You are Interested In

Information and Education	**Support**	**Wellness**
☐ Learn about latest advances in cancer treatment ☐ Learn about national and local resources ☐ Find out more information on managing treatment related side effects	☐ Connect with others in a group setting ☐ Get individual support. ☐ Learn how to manage my feelings about my cancer ☐ Caregiver support	☐ Learn about nutrition and cancer in a group setting ☐ Individual nutrition consultation ☐ Join a yoga or exercise class
Families	**Mind Body Spirit**	**Salon and Spa**
☐ Find support for children ☐ Learn how I can support my children ☐ Have fun with my children	☐ Participate in art/craft classes ☐ Learn about meditation or mindfulness ☐ Learn about complementary therapies	☐ Wig Boutique/Salon service ☐ Attend Look Good, Feel Better class ☐ Oncology massage ☐ Oncology facial ☐ Oncology skin care consultation

Release and Waiver

I, the undersigned, acknowledge that I have voluntarily chosen to participate in the classes / programs / services offered by Waterford Place Cancer Resource Center. I am aware that participation in some of these classes / programs / services may require physical exertion and a minimum level of physical fitness. I am voluntarily participating in the classes / programs / services and I assume all responsibility and liability for any and all injuries I may sustain due to my participation in these activates. In consideration for participation in the classes/programs/services I waive any claims or liability against Waterford Place Cancer Resource Center and/or the Waterford Place Cancer Resource Center staff/ instructors/other participants for injury or damages that I may sustain as a result of my participation. I understand and agree that Waterford Place Cancer Resource Center, Rush Copley Medical Center, Copley Memorial Hospital or any of their affiliates are not responsible for the loss or theft of any the Participant's personal items or valuables. Any items that remain in the Participant's possession will be their responsibility to secure. I have read the above release and waiver of liability and fully understand its contents. I voluntarily agree to the terms and conditions stated above.

Participant Name *(Please Print):* _____

Participant Signature: _____ Date: _____

If Participant is Under 18 years old:

Parent/Guardian Signature: _____ Date: _____