

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 <i>(Please Print)</i> :		Today's Date:
Street Address:		City:
State:	Zip:	County:

Date of Birth:	Gender:	Email Address:
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Preferred Phone Number: <input type="checkbox"/> Cell <input type="checkbox"/> Home	Can Waterford Place Leave a Message? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Permission to receive text reminders and notifications. **If yes, please provide your cell provider:**

Emergency Contact Name:	Your Relationship to Emergency Contact:
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Emergency Contact Phone Number:	Can Waterford Place Leave a Message? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Cancer Specific Information

Primary Cancer Type:	Cancer Stage: <input type="checkbox"/> 0 <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> unknown
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Approx. date of original cancer diagnosis:	Has cancer metastasized/spread from its original location? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Has cancer recurred? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date you learned of recurrence or metastasis:
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Physician's Name *(Medical Oncologist, Radiation Oncologist or Surgeon)*:

Physician Location:	Physician Fax Number <i>(Optional)</i> :
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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)

<p>Treatment Status</p> <p><input type="checkbox"/> Pre-treatment</p> <p><input type="checkbox"/> In Active Treatment</p> <p><input type="checkbox"/> Completed treatment (Date completed) _____</p> <p><input type="checkbox"/> Supportive or Palliative Care only</p>	<p>Current Treatment</p> <p><input type="checkbox"/> To Be Determined</p> <p><input type="checkbox"/> Watch and Wait</p> <p><input type="checkbox"/> Surgery</p> <p><input type="checkbox"/> Chemotherapy or Targeted Therapy</p> <p><input type="checkbox"/> Radiation Therapy</p> <p><input type="checkbox"/> Bone Marrow / Stem Cell Transplant</p> <p><input type="checkbox"/> Oral Hormones / Hormone Therapy</p> <p><input type="checkbox"/> Other _____</p>
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Race/Ethnicity	Medical Insurance Status	Your Primary Language
<input type="checkbox"/> White, Non-Hispanic/Latino <input type="checkbox"/> Hispanic Latino <input type="checkbox"/> Black/African-American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Pacific Islander/Hawaiian Native <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Asian <input type="checkbox"/> Other	<input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Uninsured	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____

PLEASE TURN OVER TO COMPLETE

Family Information

Adult Family Member(s) Names <i>(Currently living with you)</i>		Relationship	
Children Names <i>(Under the age of 18 and living with you)</i>		DOB	Gender

Please Check ALL the Areas You are Interested In

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