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: Approx. date of original cancer diagnosis:	Cancer Stage: ☐ 0 ☐ I ☐ II ☐ III ☐ IV ☐ unknown _____Other
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:	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	**Current Treatment**
☐ Pre-treatment ☐ In Active Treatment ☐ Completed treatment (Date completed) _____ ☐ Supportive or Palliative Care only	☐ To Be Determined ☐ Watch and Wait ☐ Surgery ☐ Chemotherapy or Targeted Therapy ☐ Radiation Therapy ☐ Bone Marrow / Stem Cell Transplant ☐ Oral Hormones / Hormone Therapy ☐ Immunotherapy

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**

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 understand that failing to show / cancel two complementary therapy services appointments will result in forfeiting any and all future complementary therapy services appointments. 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: _____