CANCER CONNECTS

Volunteer Mentor Program

Participant Registration Form

Participant's Name: _____
First Last

Address: _____
Street/Apt.

_____
City State Zip

E-Mail Address: _____

Home Phone Number: _____ Work Phone Number: _____

Cell Phone Number: _____

Date of Birth: _____/ _____/_____ Age: _____

Marital Status: _____ Single _____ Married _____ Divorced _____ Widowed

Sex: _____ Female _____ Male

Number of Children: Girls _____ Age(s) at time of diagnosis _____
Boys _____ Age(s) at time of diagnosis _____

Ethnic Origin: _____ African American _____ Asian American _____ Caucasian _____ Hispanic
_____ Native American _____ Other _____

Primary Care Physician's Name: _____
First Last
Primary Care Physician's Address: _____

Diagnosis: _____

Date of Diagnosis: _____

Referral Source
_____ Self-referral _____Health Care Provider _____ Relative / Friend _____Community Referral
_____ Mentor Volunteer _____Other (please specify) _____

Treatment (if applicable)

Surgeon's Name: _____
First Last
Surgeon's Address: _____

_____

Oncologist's Name: _____
First Last
Oncologist's Address: _____

_____

Type of Surgery (if applicable): _____

Surgery Date: _____

Treatment:

_____ Chemotherapy Date _____/ _____/ _____ Type: _____

_____ Radiation Date _____/ _____/ _____ Type: _____

_____ Hormonal Date _____/ _____/ _____ Type: _____

_____ Other Date _____/ _____/ _____ Type: _____

Are you currently undergoing treatment? _____ Yes _____ No

Additional information to help us best facilitate a mentor: _____

_____

_____

_____

_____

_____

Participant's Signature: _____

Date: _____

****

FOR OFFICE USE:

Date Registration Received: _____

Assigned Volunteer Mentor's Name: _____

Date Assigned: _____

Initial Contact Date: _____

Type of Contact: _____ Phone _____ In Person

Follow Up Contacts:

Date: ___/ ___/ ___ Type: _____ Phone _____ In Person

Date: ___/ ___/ ___ Type: _____ Phone _____ In Person

Date: ___/ ___/ ___ Type: _____ Phone _____ In Person

Date: ___/ ___/ ___ Type: _____ Phone _____ In Person

Community Referrals (if any): _____

_____

Additional Comments: _____

_____

_____

CancerConnects Volunteer Mentor Program

Participant Consent Form

- I understand as a participant in this program I will be matched with a mentor who is a cancer survivor and similar to me in terms of the cancer diagnosis when possible. My mentor will have participated in an orientation-training program.
- I understand that all CancerConnects Volunteer Mentors will keep in extreme confidence any information provided by myself and /or family members at all times. This statement covers medical status, personal or family life, and opinions expressed by myself and/or family member. Limitations to this policy are the following: suspected child abuse and neglect, dangerousness to self/others, cognitive impairment resulting in an inability to adequately care for myself.
- I understand the mentor is a layperson who is not trained to give medical or psychological advice.
- I understand the contacts with my mentor will be either over the telephone or face-to-face in a public meeting place.
- I agree to have my name, diagnosis, treatment, and telephone number given to the mentor in order for him/her to contact me.
- I understand my participation in this program is completely voluntary.
- I understand my physician will be informed that a mentor has been assigned.

Name (please print): _____

Address: _____

_____

_____

Telephone Number: _____

Cell Number: _____

Signature: _____ Date: _____