Mail Completed form to:
Gouverneur Breast & Ovarian Cancer Fund
PO Box 64
Gouverneur, NY 13642

PHYSICIAN FORM #2
Followup

Patient # _____

Date:_____

Gouverneur Breast & Ovarian Cancer Fund

Quality of Life Assistance Application

Gouverneur Breast Cancer Fund Provides Assistance to Legal Residents
of New York State, Counties of, St. Lawrence, Jefferson, Lewis and Franklin Only

CONFIDENTIAL - TO BE COMPLETED BY TREATING PHYSICIAN - PLEASE PRINT

General Patient Information

Patient Name: _____ Date of Diagnosis: _____

Diagnosis: _____

Is the patient still in treatment?: Y / N If yes, what type? _____

How long is the patient expected to remain in treatment? _____

If the patient is no longer in treatment, are they on a maintenance drug? Y / N _____

What medication is the patient currently on? _____

Does the patient need medical devices to assist with treatment or recovery? Y / N — Are they able to return to work? Y / N

Please list any Comments pertaining this patient's situation you feel the GBCF needs to be aware of:

_____

_____

_____

_____

_____

Physician's Name: _____

Physician's Address: _____ Phone: _____

Physician's Signature: _____ Date: _____

Note:

NOTE: Patient will not receive additional funding until the GBOCF receives this completed form.