waterfordplace
Cancer Resource Center

Participant Information Form

Waterford Place will use your personal information to register and record only and will not share it with external sources. Your information also helps develop and recommend programs while allowing Waterford Place to raise funds to continue serving cancer-affected people in the most effective ways possible. Waterford Place Cancer Resource Center is a Rush Copley Medical Center community program. Rush Copley complies with applicable Federal civil rights laws and does not discriminate based on race, color, religion, national origin, age, disability, sex, sexual orientation, or gender identity and/or expression. Rush Copley does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Name *(Please Print)*:			Today's Date:
Preferred Name *(Please Print)*:			Preferred Pronouns:
Street Address:			
City:	State:	Zip:	County:
Date of Birth:	Gender:	Sexual Orientation:	
Email Address:			

Preferred Phone Number ☐Cell ☐Home	Can Waterford Place leave a message? ☐Yes ☐No
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: ☐ Zero ☐ One ☐ Two ☐ Three ☐ Four ☐ Unknown
Approx. date of original cancer diagnosis:	☐ 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	☐Surgery ☐Watch and Wait ☐To Be Determined ☐Chemotherapy ☐Targeted Therapy ☐Radiation Therapy ☐Bone Marrow / Stem Cell Transplant ☐Immunotherapy ☐Oral Hormones / Hormone Therapy

Race/Ethnicity	**Faith Tradition**	**Your Primary Language**
☐ White, Non-Hispanic/Latino ☐ Hispanic Latino ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Pacific Islander/Hawaiian Native ☐ Multi-Racial ☐ Asian ☐ Other	☐ Judaism ☐ Christianity ☐ Islam ☐ Hinduism ☐ Buddhism ☐ Other	☐ English ☐ Spanish ☐ Other: ____________ **Medical Insurance Status** ☐ Private Insurance ☐ Medicare ☐ Medicaid ☐ Uninsured

Support Information

Adults *(Currently living with you)*	**Relationship**	
Children *(Under the age of eighteen and living with you)*	**DOB**	**Relationship**

Family Income

In our efforts to provide helpful resource to all participants and for grant reporting purposes, Waterford Place is requesting family household size and income information. The information you provide will remain confidential. Please indicate family size and estimated annual income level.

Family Size	**Estimated Annual Income**	
	Below	Over
☐ 1	☐ $75,000	☐ $75,000
☐ 2	☐ $102,000	☐ $102,000
☐ 3	☐ $128,000	☐ $128,000
☐ 4	☐ $155,000	☐ $155,000
☐ 5	☐ $181,000	☐ $181,000

Release and Waiver

I, the undersigned, have voluntarily chosen to participate in the classes / programs / services offered by Waterford Place Cancer Resource Center. I understand that participation in certain classes / programs / services may require physical exertion and a minimum level of physical fitness. I agree to assume all responsibility and liability for all injuries I may sustain due to my participation in these activities. In consideration for participation in the classes/programs/services, I agree to release, acquit and discharge Waterford Place Cancer Resource Center, Rush Copley Medical Center, Inc., and Copley Memorial Hospital, Inc. of and from any and all liability of any kind or nature, including theft or loss of personal property on account of or in any way related to my participation at Waterford Place Cancer Resource Center. I further understand and agree that failing to show for two complementary therapy services appointments will result in forfeiting 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 Signature:____Date: ______________

If Participant is Under 18 years old:
Parent/Guardian Signature:____Date: ______________

For Office Use Only

☐ Pre-Treatment/ In Treatment (Unlimited sessions for 18 months from date of Dx)	Activation Date (Date of Dx/Recurrence):
☐ Completed Treatment (12 sessions for 24 months from date of treatment completion)	Activation Date (Date Completed Treatment):
☐ Metastatic/Advanced Stage (Unlimited sessions indefinitely)	
F.T. Score	☐ SGK Eligible