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. Waterford Place Cancer Resource Center is a community program of Rush Copley Medical Center. Rush Copley complies with applicable Federal civil rights laws and does not discriminate on the basis of 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: ☐ 0 ☐ I ☐ II ☐ III ☐ IV ☐ unknown _______________Other
Approx. date of original cancer diagnosis:	

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	☐ To Be Determined ☐ Watch and Wait
☐ In Active Treatment	☐ Surgery
☐ Completed treatment (Date completed) _______________	☐ Chemotherapy or Targeted Therapy
☐ Supportive or Palliative Care only	☐ Radiation Therapy
	☐ Bone Marrow / Stem Cell Transplant
	☐ Oral Hormones / Hormone Therapy
	☐ Immunotherapy

Race/Ethnicity	If Hispanic/Latino	Your Primary Language
☐ White, Non-Hispanic/Latino	☐ Colombian	☐ English ☐ Spanish
☐ Hispanic Latino	☐ Cuban	☐ Other: __________________
☐ Black/African-American	☐ Dominican	
☐ American Indian/Alaskan Native	☐ Mexican/Mexican-American/Chicano	**Medical Insurance Status**
☐ Pacific Islander/Hawaiian Native	☐ Puerto Rican	☐ Private Insurance
☐ Multi-Racial	☐ Salvadoran	☐ Medicare ☐ Medicaid
☐ Asian ☐ Other	☐ Other Hispanic/Latino/Spanish origin	☐ Uninsured

Support Information

Adults *(Currently living with you)*	**Relationship**	
Children *(Under the age of 18 and living with you)*	**DOB**	**Gender**

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, 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 for 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 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 (3 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