

## **PART 3: VERIFICATION OF DIAGNOSIS**

### **To Be Completed By Certifying Healthcare Professional:**

#### **To Be Completed by Physician, Nurse, Social Worker or Case Worker Only:** **Medical Information**

Name of Applicant: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_

Stage of Breast Cancer: \_\_\_\_\_  New Diagnosis  Recurrence

In Active Treatment?  Yes  No

⇒ **If Yes**, please indicate type of treatment (check all that apply):

Chemotherapy  Radiation  Targeted/Biologic Therapy  
 Hormonal  Surgery  Palliative Care

⇒ **If No**, is this woman attending her follow-up appointments?  Yes  No

**If Yes**, please indicate frequency of follow up:

Yearly  Every Six Months  Every Three Months  Other \_\_\_\_\_

Provider Name: \_\_\_\_\_

Hospital/Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Signature of person completing this section: \_\_\_\_\_

Print Name/Title: \_\_\_\_\_

Phone (if different than above): \_\_\_\_\_

E-mail address: \_\_\_\_\_

Relationship to Person Applying for Assistance:  Doctor  Nurse  Social Worker  Case Worker