Cancer Treatment Centers of America®

Winning the fight against cancer, every day.®

Instructions for Returning these Forms

There are three ways to return your completed forms. Please choose the option that is most convenient for you:

1. **Email** the completed forms to your Oncology Information Specialist.
   (For this option, you need to complete and print the forms. Sign the Authorization Form and then email the scanned forms to your Oncology Information Specialist.)

OR

2. **Fax** the completed forms to the appropriate hospital.

   Eastern Regional Medical Center (Philadelphia): 215-537-5116

   Midwestern Regional Medical Center (Chicago): 847-746-6584

   Southeastern Regional Medical Center (Atlanta): 770-400-6801

   Southwestern Regional Medical Center (Tulsa): 918-249-7521

   Western Regional Medical Center (Phoenix): 623-932-8596

OR

3. **Mail** the completed forms to the appropriate hospital.
   (This option may delay processing.)

Eastern Regional Medical Center
Attention: New Patient Intake
1331 East Wyoming Avenue
Philadelphia, Pennsylvania 19124

Midwestern Regional Medical Center
Attention: New Patient Coordinator
2520 Elisha Avenue
Zion, Illinois 60099

Southeastern Regional Medical Center
Attention: New Patient Intake
600 Parkway North
Newnan, Georgia 30265

Southwestern Regional Medical Center
Attention: Intake Department—New Patient Record Collections
10109 East 79th Street
Tulsa, Oklahoma 74133-1200

Western Regional Medical Center
Attention: New Patient Scheduling
14200 West Fillmore Street
Goodyear, Arizona 85338

NOTE: As a convenience to you, UPS will attempt to pick up your completed forms from the location where this package was delivered one day after the initial delivery. Simply complete the forms and place them in the included UPS envelope. There is no charge to you for this service.

PRIVACY OFFICE CONTACT INFORMATION

Eastern Regional Medical Center
215-537-7400

Midwestern Regional Medical Center
847-872-6368

Southeastern Regional Medical Center
770-400-6000

Southwestern Regional Medical Center
918-286-5355

Western Regional Medical Center
623-207-3145

Medical History Form

Form 1 of 3

In order to prepare for your evaluation and create a personalized treatment plan at Cancer Treatment Centers of America® (CTCA), we need to collect your past medical records. The information we collect allows us to review your medical records prior to your appointment at CTCA®. This is necessary to provide you with a thorough medical evaluation.

Please complete these three (3) forms using either a BLUE or BLACK pen or typing into the blanks and checking the appropriate boxes. Please include information from the time of diagnosis through the present. We use this information to request copies of your medical records from your providers.

Please complete all three (3) medical history forms and immediately return to us.

- ☐ Eastern Regional Med. Ctr. (Philadelphia)
- ☐ Midwestern Regional Med. Ctr. (Chicago)
- ☐ Southeastern Regional Med. Ctr. (Atlanta)
- ☐ Southwestern Regional Med. Ctr. (Tulsa)
- ☐ Western Regional Med. Ctr. (Phoenix)

PATIENT NAME *(Last, First, Middle)* **DATE OF BIRTH**

PREVIOUS NAME *(Due to marriage, adoption or other reasons)*

Current Cancer Diagnosis/Suspected Diagnosis

I was diagnosed with:

Name of Cancer *(For example: prostate, breast, lymphoma, etc.)*	Date of Diagnosis *(Month/Year)*

☐ I have received treatments for this cancer.
☐ I have not yet received treatments for this cancer. *(Skip "Cancer Treatment" section in form 2)*

Previous Cancer Diagnosis

I was previously diagnosed with:

Name of Cancer *(For example: prostate, breast, lymphoma, etc.)*	Date of Diagnosis *(Month/Year)*

Cancer Diagnosis

Include any doctor, hospital or medical center that performed testing, physical exams, labs, radiologic scans, biopsies or office visits that helped diagnose any cancers. Please use Form 3 to share your mammogram information.

Facility/Physician Name

City, State | Phone Number

Please check the box(es) for testing/diagnostic procedures performed at this facility:

☐ X-ray, PET, CT, Bone Scan, Ultrasound, MRI ☐ Surgery
☐ Biopsy ☐ Blood Work/Labs ☐ Hospital Stay/Overnight
☐ ER Visit/Outpatient ☐ Other _____

☐ Hospital
☐ Physician
☐ Medical Center
☐ Other

Date of Last Visit *(Month/Year)*

Facility/Physician Name

City, State | Phone Number

Please check the box(es) for testing/diagnostic procedures performed at this facility:

☐ X-ray, PET, CT, Bone Scan, Ultrasound, MRI ☐ Surgery
☐ Biopsy ☐ Blood Work/Labs ☐ Hospital Stay/Overnight
☐ ER Visit/Outpatient ☐ Other _____

☐ Hospital
☐ Physician
☐ Medical Center
☐ Other

Date of Last Visit *(Month/Year)*

☐ **I have seen additional physicians at other facilities for my cancer diagnosis.**

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Medical History Form

Form 2 of 3

Please complete these three (3) forms using either a BLUE or BLACK pen or typing into the blanks and checking the appropriate boxes. Please include information from the time of diagnosis through the present. We use this information to request copies of your medical records from your providers.

Please complete all three (3) medical history forms and immediately return to us.

- ☐ Eastern Regional Med. Ctr. (Philadelphia)
- ☐ Midwestern Regional Med. Ctr. (Chicago)
- ☐ Southeastern Regional Med. Ctr. (Atlanta)
- ☐ Southwestern Regional Med. Ctr. (Tulsa)
- ☐ Western Regional Med. Ctr. (Phoenix)

PATIENT NAME *(Last, First, Middle)* **DATE OF BIRTH**

Cancer Treatment

Include any doctor, hospital or medical center that performed cancer treatment for this or previous cancers including chemotherapy, radiation, surgery, naturopathic, pain management or other types of treatment. If you have never been treated, you may skip this section.

Facility/Physician Name

City, State | Phone Number

Please check the box(es) for testing/diagnostic procedures performed at this facility:

☐ X-ray, PET, CT, Bone Scan, Ultrasound, MRI ☐ Surgery
☐ Biopsy ☐ Blood Work/Labs ☐ Chemotherapy ☐ Radiation
☐ Naturopathic ☐ Supplements ☐ Other ____________

☐ Hospital
☐ Physician
☐ Medical Center
☐ Other

Date of Last Visit *(Month/Year)* ____________

Facility/Physician Name

City, State | Phone Number

Please check the box(es) for testing/diagnostic procedures performed at this facility:

☐ X-ray, PET, CT, Bone Scan, Ultrasound, MRI ☐ Surgery
☐ Biopsy ☐ Blood Work/Labs ☐ Chemotherapy ☐ Radiation
☐ Naturopathic ☐ Supplements ☐ Other ____________

☐ Hospital
☐ Physician
☐ Medical Center
☐ Other

Date of Last Visit *(Month/Year)* ____________

Facility/Physician Name

City, State | Phone Number

Please check the box(es) for testing/diagnostic procedures performed at this facility:

☐ X-ray, PET, CT, Bone Scan, Ultrasound, MRI ☐ Surgery
☐ Biopsy ☐ Blood Work/Labs ☐ Chemotherapy ☐ Radiation
☐ Naturopathic ☐ Supplements ☐ Other ____________

☐ Hospital
☐ Physician
☐ Medical Center
☐ Other

Date of Last Visit *(Month/Year)* ____________

☐ **I have seen additional physicians at other facilities for my cancer treatment.**

Primary Care Physician

Include the doctor, hospital or medical center that currently manages your routine health care needs.

Physician/Facility Name

City, State | Phone Number

Date of Last Visit with this Physician *(Month/Year)*

☐ Hospital
☐ Physician
☐ Medical Center
☐ Other

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Medical History Form

Form 3 of 3

If you are a male patient and this page does not apply to you, we ask that you still send it back with your name and date of birth at the top.

Please complete these three (3) forms using either a BLUE or BLACK pen or typing into the blanks and checking the appropriate boxes. Please include information from the time of diagnosis through the present. We use this information to request copies of your medical records from your providers.

Please complete all three (3) medical history forms and immediately return to us.

- ☐ Eastern Regional Med. Ctr. (Philadelphia)
- ☐ Midwestern Regional Med. Ctr. (Chicago)
- ☐ Southeastern Regional Med. Ctr. (Atlanta)
- ☐ Southwestern Regional Med. Ctr. (Tulsa)
- ☐ Western Regional Med. Ctr. (Phoenix)

PATIENT NAME *(Last, First, Middle)* **DATE OF BIRTH**

OB/GYN Physician

Female patients only: Include the doctor, hospital or medical center that currently manages your reproductive health care needs.

Physician/Facility Name

City, State | Phone Number

Date of Last Visit with this Physician *(Month/Year)*

☐ Hospital ☐ Physician ☐ Medical Center ☐ Other

Mammogram

Include your most recent mammogram even if you are not being treated for breast cancer. If you have never had one, just state "none" on the Physician/Facility Name line.

My most recent mammogram was performed at:

Physician/Facility Name

City, State | Phone Number

Date of Last Mammogram *(Month/Year)*

☐ Hospital ☐ Physician ☐ Medical Center ☐ Other

Breast Cancer Patients Only

We need to collect additional mammogram details from male and female breast cancer patients.

Please check one:

- ☐ **I have had only one mammogram (listed above).**
- ☐ **All of my mammograms were performed at the facility listed above.**
- ☐ **I have had additional mammograms performed at/by the following physicians/facilities:**

Facility/Physician Name

City, State | Phone Number

Mammogram Dates *(Month/Year)*

☐ Hospital ☐ Physician ☐ Medical Center ☐ Other

Facility/Physician Name

City, State | Phone Number

Mammogram Dates *(Month/Year)*

☐ Hospital ☐ Physician ☐ Medical Center ☐ Other

Facility/Physician Name

City, State | Phone Number

Mammogram Dates *(Month/Year)*

☐ Hospital ☐ Physician ☐ Medical Center ☐ Other

☐ **I have seen additional physicians at other facilities for mammograms.**

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