CANCER CONNECTS

Patient Buddy Program

Participant Application Form

☐ Auxiliary Mentoring ☐ Traditional Mentoring

Auxiliary Mentoring: Occasional check-ins and messages of encouragement

Traditional Mentoring: More consistent check-ins and on-going communication

Participant's Name: _____

First Last

Address: _____

Street/Apt.

_____

City State Zip

E-Mail Address: _____

Home Phone Number: _____ **Cell Phone Number:** _____

Preferred Contact: ☐ Email ☐ Home Phone ☐ Cell Phone

Date of Birth: _____/ _____/_____ **Age:** _____ **Sex:** ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Number of Children: Girls _____ Age(s) at time of diagnosis _____

Boys _____ Age(s) at time of diagnosis _____

Ethnic Origin: ☐ African American ☐ Asian American ☐ Caucasian ☐ Hispanic/Latino ☐ Native American ☐ Other _____

Referral Source: ☐ Self-referral ☐ Healthcare Provider ☐ Relative / Friend ☐ Mentor Volunteer ☐ Community Organization or Agency ☐ Other (please specify) _____

Primary Care Physician and/or Oncologist Name: _____

_____

Physician's Address: _____

Diagnosis: _____ **Date of Diagnosis:** _____

Treatment (if applicable)

Are you currently undergoing treatment? ☐ Yes ☐ No

_____ Chemotherapy Date ___/___/___ Type: _____

_____ Radiation Date ___/___/___ Type: _____

_____ Hormonal Date ___/___/___ Type: _____

_____ Other Date ___/___/___ Type: _____

_____ Surgery Date ___/___/___ Type: _____

Please check your top three choice on how you would like to be connected to a mentor:

☐ Diagnosis ☐ Stage ☐ Treatment Plan ☐ Race
☐ Marital Status ☐ Employment ☐ Children ☐ Gender ☐ Age

Additional information to help us best match you to a mentor: _____
_____
_____
_____
_____

Participant's Signature: _____ **Date:** _____

Please return your application to:

CancerConnects, Inc.
Attn: Administrative Specialist
PO Box 2010
East Syracuse, NY 13057

or by email to:
officecancerconnects@gmail.com

****

FOR OFFICE USE:

Date Application Received: _____ Date Assigned: _____

Assigned Volunteer Mentor's Name: _____

Initial Contact Date: _____ Type of Contact: ☐ Phone ☐ In Person ☐ Email

Community Referrals (if any): _____
_____
_____

Additional Comments: _____
_____
_____

CancerConnects Patient Buddy Program
Participant Consent Form

- I understand as a participant in this program I will be matched with a mentor who is a cancer survivor and similar to me in preferred ways indicated on my application when possible. My mentor will have participated in an orientation-training program.
- I understand that all CancerConnects Volunteer Mentors will keep in extreme confidence any information provided by myself and/or family members at all times. This statement covers medical status, personal or family life, and opinions expressed by myself and/or family members. Limitations to this policy are the following: suspected child abuse and neglect, dangerousness to self/others, cognitive impairment resulting in an inability to adequately care for myself.
- I understand the mentor is a layperson who is not trained to give medial or psychological advice.
- I understand the contact with my mentor will be either over telephone, e-mail, or face-to-face in a public meeting place.
- I agree to have my name, diagnosis, treatment plan, and contact information given to the mentor in order for him/her to contact me.
- I understand my participation in this program is completely voluntary.

Name (please print): _____
Address: _____
_____
Phone Number: _____
Email: _____

Signature: _____ Date: _____