Mail Completed form to:
Gouverneur Breast & Ovarian Cancer Fund
PO Box 64
Gouverneur, NY 13642

PHYSICIAN FORM #1

Patient # _____

Date:_____

Gouverneur Breast & Ovarian Cancer Fund

Quality of Life Assistance Application

Gouverneur Breast Cancer Fund Provides Assistance to Legal Residents of New York State,
Counties of, St. Lawrence, Jefferson, Lewis and Franklin Only

CONFIDENTIAL - TO BE COMPLETED BY TREATING PHYSICIAN - PLEASE PRINT

General Patient Information:

Patient Name: _____ Date of Diagnosis: _____

Diagnosis: _____

Diagnosis know to Patient? Yes: ____ No: ____ Diagnosis know to family? Yes: ____ No: ____

Type of treatment: _____

_____

_____

_____

Financial Assistance with Transportation:

Treatment location: _____

_____

Is the Patient Ambulatory? Yes: ____ No: ____

Financial Assistance with Medication

Please list class of medication and specific drugs related to Patient's Cancer:

Class of Medication:	Specific Drug:
_____	_____
_____	_____
_____	_____
_____	_____

Please list any Comments pertaining this patient's situation you feel the GBCF needs to be aware of:

_____

_____

_____

_____

_____

Physician's Name: _____

Physician's Address: _____ Phone: _____

Physician's Signature: _____ Date: _____