Physician Application and Consent Form

WOMEN

Submit Form

PATIENT INFORMATION

Last name _____ First name _____ Middle _____

Address _____

City _____ Province _____ Postal Code _____

Date of Birth (yyyy/mm/dd) _____

ONCOLOGIST INFORMATION

Last name _____ First name _____

Address _____

City _____ Province _____ Postal Code _____

Phone/Ext ( ) _____ Fax ( ) _____

Email _____

Treatment centre's Power of Hope administrator (if known) Name _____

Phone/Ext ( ) _____ Fax ( ) _____

Email _____

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HEALTH INFORMATION OF PATIENT

Cancer Type: _____

Past treatment and dates of treatment completed (if applicable):

_____

_____

If the patient has had a history of cancer and treatment has already occurred:

- At least one year must have passed since completing that treatment, and;
- Additional cancer treatment is planned imminently that will further affect fertility.

Treatment Plan (please indicate location of surgery, type of chemotherapy, location(s) and dose of radiation, if applicable):

_____

_____

PLEASE NOTE: Only complete applications that include the information as outlined on page 2 of this application will be processed.

☐ I believe that this patient's cancer treatment presents a risk to his fertility and support fertility preservation as a safe and appropriate option for this patient.

Oncologist Signature: _____ Date (yyyy/mm/dd) _____

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