



ENROLLMENT FORM

Name: _____ **Date of Application:** _____
First Last

Home Address: _____
Street City State Zip

Telephone #: _____
Home Cellular Other

Email address: _____

Date of Initial Diagnosis: _____ **Primary Treating Physician:** _____

Stage of Breast Cancer at Initial Diagnosis: _____ **Current Stage:** _____

Treatment History (CHECK ALL THAT APPLY & NOTE DATE ON LINE**)**

	<i>PAST</i>	<i>PRESENT</i>	<i>FUTURE</i>
Lumpectomy	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Partial Mastectomy	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Single Mastectomy	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Double Mastectomy	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Reconstruction for mastectomy	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Lymph Node Dissection	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Chemotherapy	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Radiation Therapy	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Hormone Therapy (e.g., Tamoxifen, Arimidex)	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Targeted Therapies (e.g., Herceptin, Avastin, Tykerb)	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____



REQUEST FOR SERVICES FORM

Please indicate the item(s) or service(s) for which you are applying:

- | | |
|---|---|
| <input type="checkbox"/> Mastectomy Bra or Compression Vest | <input type="checkbox"/> Breast or Nipple Prosthetics |
| <input type="checkbox"/> Mastectomy Swimwear | <input type="checkbox"/> Post-Surgical Camisole |
| <input type="checkbox"/> Mastectomy Sleepwear | <input type="checkbox"/> Post-Surgical Pillow |
| <input type="checkbox"/> Wig | <input type="checkbox"/> Head Coverings |
| <input type="checkbox"/> Lymphedema Products | |
| <input type="checkbox"/> Facial | <input type="checkbox"/> Manicure/Pedicure |
| <input type="checkbox"/> Massage | <input type="checkbox"/> Oncology Skincare Products |
| <input type="checkbox"/> Salon Service on Wig | <input type="checkbox"/> Pampering Products |
| <input type="checkbox"/> Yoga or Exercise Class | |
| <input type="checkbox"/> Other (please specify): _____ | |

Please browse the synthetic wigs at Wigs.com and list selections in order of preference:

Brand: _____	Style/Model Name: _____
Color: _____	Size: _____ (NOTE: Take careful measurements to ensure proper fit!)
Brand: _____	Style/Model Name: _____
Color: _____	Size: _____ (NOTE: Take careful measurements to ensure proper fit!)

Orders for mastectomy garments and prosthetics are handled ONLY after fitting with certified mastectomy fitter. Please contact us for more information.



DEMOGRAPHIC INFORMATION FORM

We request the following information to enable us to track the changing demographics of the women we serve. The information may also be used by government institutions or funding sources to which we apply for grants to continue our work. Any such information provided to these agencies will be referenced only as part of a combined demographic report of ALL of our awardees. Your privacy and anonymity will be strictly maintained at all times. Your decision to provide this information is completely voluntary, and will never affect your eligibility for our services.

Age at initial diagnosis: _____ **Current age:** _____

Marital status: Single Married Separated Divorced Widowed Other

Race/Ethnicity: White/Non-Hispanic Hispanic/Latino Black/African American Asian
 American Indian/Alaska Native Native Hawaiian/Pacific Islander Other

Citizenship: US Citizen Permanent Resident Non-immigrant Student or Visitor
 Other (explain): _____

Employment: Active Military Disabled Employed Full-Time Employed Part-Time
 Homemaker Not Employed Retired Self-Employed Student Other

Household income before taxes (includes you and any others over 18 with an income): _____

Number of children/dependents residing in your home: _____

Do you have health insurance? Yes No

If yes, list needed items NOT covered by your policy: _____

How did you hear about us? Family Member Friend Physician/Nurse/Social Worker
 Our brochure Internet (e.g., Google, Facebook, etc.) News Media (magazine, newspaper, radio, TV) Other