PATIENT APPLICATION

Since every woman has an individual treatment plan, we carefully match newly diagnosed women with a peer mentor who has gone through a comparable experience. Peer Mentors receive formal training. If you are willing to share aspects of your experience, including information about your treatment decisions, effects of treatment, coping strategies, recovery obstacles, knowledge, support, encouragement, and friendship, then we encourage you to submit an application. *Note: We are committed to your privacy and your information will never be shared with an outside party other than those affiliated with the LCBF Woman to Woman Program.*

PATIENT INFORMATION			
Name:			Date: ___/____/_____
Date of birth: ___/____/_____	Age:		Cell Phone: : (____)_____ Home Phone: : (____)_____
Current address:			
City:	State:	ZIP Code:	
Email address:		Preferred contact method? ◯Cell Phone ◯ Home Phone ◯ Email For phone, preferred time? _____	
Primary language:	Other language(s):		If your race and/or ethnicity is an element you would like to share, please write that information here:
Marital status: ◯ Single ◯ Married ◯ Divorced ◯ Widow ◯ Significant Other	Do you have children? ◯ YES ◯ NO If yes, ages: _____ _____ _____		Do you currently live alone? ◯ YES ◯ NO Do you have children living at home? ◯ YES ◯ NO
Religious Affiliation:			Congregation:
Are you currently employed? ◯ YES ◯ NO	Place of employment: _____		Position: _____

YOUR CANCER JOURNEY		
Type of Cancer:	Date Diagnosed (MM/DD/YYYY): ___/____/_____	Cancer stage:
Has your cancer metastasized? ◯ YES ◯ NO	If yes, location(s):_____	
Hospital/Medical Center you are being treated:	City: _____ State:_____	Treating Doctor: _____ Contact Number: (____)_____

Current treatments: (Choose all that apply):

◯ Chemotherapy; if yes, what drugs: _____
◯ Surgery; type:_____
◯ Other; please explain: _____
_____
◯ Radiation
◯ Clinical Trial; if yes, which one: _____
◯ Alternative Treatment; if yes, which one: _____
◯ Wait and watch

Please let us know of any therapies and practices you are interested in using or learning more about to manage the physical and emotional symptoms of gynecologic cancer: (Choose all that apply):		
	◯ Art Therapy ◯ Acupuncture ◯ Aromatherapy ◯ Chiropractic Therapy ◯ Diet and Nutrition ◯ Exercise ◯ Hypnosis ◯ Journaling ◯ Massage ◯ Meditation	◯ Music Therapy ◯ Natural Products ◯ Physical Therapy ◯ Psychotherapy ◯ Reiki ◯ Shiatsu ◯ Spirituality and Prayer ◯ Support Groups ◯ Tai Chi ◯ Yoga

PEER TO PEER COMMUNICATION

Do you feel comfortable being matched with a mentor who has a different gynecologic cancer type than yours? ◯ YES ◯ NO

Do you feel comfortable being matched with a mentor who has a different treatment history than yours? ◯ YES ◯ NO

How would you prefer to communicate with your mentor? (Choose all that apply)
◯ Phone
◯ Text messaging
◯ Video chat
◯ Email
◯ In Person; if yes, max travel radius in miles: _____

How often do you think you would like to communicate with your mentor? (Choose all that apply)
◯ Daily
◯ Weekly
◯ Every other week
◯ I'm not sure
◯ As much as needed

What are your hobbies, interests, and favorite ways to relax? _____
_____
_____
_____

Mentor Characteristics	**Importance for Your Match with Mentor:** (1= least important, 5 =most important)
Age	1 2 3 4 5
Diagnosis	1 2 3 4 5
Treatment	1 2 3 4 5
Race	1 2 3 4 5
Religion	1 2 3 4 5
Marital status	1 2 3 4 5
Family	1 2 3 4 5
Location	1 2 3 4 5
Hobbies	1 2 3 4 5

Are there any other characteristics that are important to you in being matched with a mentor?

◯ YES ◯ NO

If yes, please explain:
_____
_____
_____
_____

Is there anything else about your journey that you would like to share? (e.g. genetic testing, family dynamics, special circumstances):
_____
_____
_____
_____
_____
_____
_____
_____

For questions, please contact Ayushe Sharma, Interim Program Coordinator, at 205-783-1285 or A.Sharma@ThinkofLaura.org.

You can return this application to Ayushe Sharma by mail, e-mail, or fax.
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Birmingham, AL 35260

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