PHYSICIAN REPORT

The individual listed below has requested financial assistance from Cancer Angels of San Diego and has stated that s/he is unable to work or is unable to work at pre-treatment level. A signed release for the requested information is attached. Please complete this form and return it to:

Attn: Client Services
Cancer Angels of San Diego
2240 Encinitas Blvd, #D, P.O. Box 327, Encinitas, CA 92024
FAX: 419-710-2198

SECTION I			
Name:			
Date of birth:		Social Security #:	
Physician's Name:		Physician's phone:	
Physician's Address:			
SECTION II – TO BE COMPLETED BY YOUR PHYSICIAN			
Diagnosis:			
Date of onset:		Date of last appointment:	
Pertinent pathology results (attach copy of report if available):			
Medications prescribed:			
Indicate client's prognosis:			
Specific physical limitations:			
Is patient's condition suitable for employment? ☐ **Yes** ☐ **No**			
What level of employment activity is suitable for patient? ☐ Part-time ____ hours per week ☐ Full-time			
Projected date patient can return to work at pre-treatment level:			
Planned surgeries – list date and expected date of recovery:			
Other planned treatments (chemo, radiation, etc.) – list projected end date:			
Comments:			
Physician's signature:	Date Signed:		