



Patient Diagnosis Verification Form

To be completed by the physician

Patient Name: _____ Date of birth: _____

Patient Diagnosis Information

Is the patient currently being treated for an ACTIVE cancer diagnosis with either chemotherapy or radiation therapy.

- Yes
 No

Initial Date of Diagnosis: _____

Estimated Length of Treatment: _____

Physician Information *(all fields **must** be completed)*

Physician Name: _____ NPI# _____

Physician Specialty:

- Oncologist
 Hematologist
 Primary Care

Facility/Practice Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Telephone: _____ Fax: _____

Office Contact Name: _____ Email: _____

I attest that the information is complete, accurate and supported in the patient's medical record. This information is for the intended use of Hope Floats Cancer Organization in order to verify the patient's eligibility for participation in our organization. This assistance is temporary and the patient may be asked to reapply at designation intervals.

Physician's Signature: _____ Date: _____