

CLINICAL TRIALS REQUEST FORM

From: _____

Phone: _____ **Fax:** _____

You'll hear from us within 48 hours with the status of your request (excluding weekends and holidays).

Patient name _____ **Gender** _____ **Date of birth** _____

Diagnosis _____ **Date of diagnosis** _____

Histology _____

Stage _____ **Metastasis** _____

Current status _____

Other medical conditions _____

Breast:

Path report: ER _____ PR _____ ; Her-2/neu: IHC _____ or FISH _____ ; Nuclear Gr. _____

Prostate ca:

Hormonal status: _____ **PSA** _____ **Date started:** _____

Previous Treatments

Surgery _____ **Date** _____

Surgery _____ **Date** _____

Chemotherapy _____

Date received _____ **Date completed** _____ **Number of courses** _____

Chemotherapy _____

Date received _____ **Date completed** _____ **Number of courses** _____

Chemotherapy _____

Date received _____ **Date completed** _____ **Number of courses** _____

XRT (area) _____ **Doses** _____

Date received _____ **Date completed** _____

Comments _____