

Camelot Cancer Care, Inc.
Free Consultation Request Form
(Please print legibly and fill out completely. Fax to 918-493-6589)

Patient's Name: _____ **M/F** _____ **Age:** _____ **DOB:** _____

Phone: _____ **e-mail:** _____

Diagnosis/Cancer Type: _____ **Stage:** _____

Metastatic: Yes No **Where:** _____

Primary site of cancer: _____

Symptoms: _____

Hospice: Check the box if the patient is currently in a hospice program or requires/will require palliative care.

Vascular Access (Circle One): Picc Line Port None

Chemo: Yes No (Please print below. If not applicable, please write N/A)

Chemo: _____ **How many:** _____ **Date of Last Dose:** _____

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Radiation: Yes No (Please print below. If not applicable, please write N/A)

Type: _____ **How many:** _____ **Date of Last Session:** _____

Type: _____ **How many:** _____ **Date of Last Session:** _____

Surgery related to cancer: Yes No (Please print below. If not applicable, write N/A)

Procedure: _____ **Date:** _____

Procedure: _____ **Date:** _____

Current Medications: _____

Alternative Treatments: _____

PET Scan Date: _____ **MRI Date:** _____ **CT Date:** _____