DATE: ____________________

SUPPORT GROUP PARTICIPANT INFORMATION SHEET

NAME: ____
FIRST LAST

MAILING ADDRESS: ____
STREET CITY STATE ZIP

E-MAIL ADDRESS: ____

HOME PHONE NUMBER: _____________________ **CELL PHONE NUMBER:** ________________________

DATE OF DIAGNOSIS: _____ / _____ / _____ **STAGE OF CANCER:** ______________________________

TYPE OF OVARIAN CANCER: ____

(Please tell us the subtype. Serous; epithelial, mucinous, endometrioid,
Clear cell, Germ cell, Fallopian tube, Primary Peritoneal, GCT, Low-grade borderline, Stromal)

DOCTOR(S) ________________________________**SURGERY/HOSPITAL** ______________________________

DO YOU HAVE A FAMILY HISTORY OF CANCER? YES ☐ NO ☐ IF YES, WHOM: _____________________

HAVE YOU HAD GENETIC COUNSELING AND TESTING? YES ☐ NO ☐

WOULD YOU LIKE TO BE ON OUR GROUP ROSTER? YES ☐ NO ☐

Answer **YES** to give your permission to allow the personal information above to be included on the group roster, which is a hardcopy distributed to all women in the group. You can contact the group facilitator at any time if you reconsider and want your information removed from the list. If you do not want to share your personal information, please select **NO**.

PLEASE ADD MY NAME TO EMAIL LIST FOR SUPPORT GROUP: YES ☐ **NO** ☐

PLEASE ADD MY NAME TO THE EAMIL LIST FOR OVARIAN CANCER PROJECT UPDATES: YES ☐ NO ☐

HOW DID YOU HEAR ABOUT THE OVARIAN CANCER PROJECT? _____________________________________

SUPPORT CONTACT (IN CASE OF EMERGENCY: ____

RELATIONSHIP: ________________________________ **PHONE NUMBER:** _________________________________

Please submit your application via email to: kkurtz@ovariancancerproject.org

OR Mail your application to:

Ovarian Cancer Project
ATTN: Kathy Kurtz, LCSW
P.O. Box 1002
Williamsville, NY 14231

Questions? Call us **716-458-0382** we are here for you!

Empowering Women through Education & Support