APPLICATION TO REQUEST A MENTOR

PART 1: DEMOGRAPHIC INFORMATION

TODAY'S DATE: _____ **DATE OF BIRTH:** _____ / _____ / _____ **AGE:** _____

NAME: _____
FIRST LAST

MAILING ADDRESS: _____
STREET CITY STATE ZIP

E-MAIL ADDRESS: _____

HOME PHONE NUMBER: _____ **CELL PHONE NUMBER:** _____

RELATIONSHIP STATUS: ☐ SINGLE, NEVER MARRIED ☐ MARRIED ☐ DIVORCED/SEPARATED
☐ WIDOWED ☐ DOMESTIC PARTNERSHIP
NAME OF SPOUSE/PARTNER: _____

CHILDREN: SONS _____ AGE(S) AT TIME OF DIAGNOSIS: _____
DAUGHTERS_____ AGE(S) AT TIME OF DIAGNOSIS: _____

RACE: ☐ AFRICAN AMERICAN ☐ ASIAN ☐ CAUCASIAN ☐ HISPANIC ☐ NATIVE AMERICAN
☐ OTHER (PLEASE SPECIFY) _____

EDUCATION: ☐ GED ☐ HIGH SCHOOL ☐ COLLEGE ☐ GRADUATE SCHOOL

OCCUPATION: _____

LANGUAGE(S) YOU CONVERSATIONALLY SPEAK OTHER THAN ENGLISH: _____

HOBBIES: _____

MOST CONVENIENT TIMES FOR YOU TO BE REACHED:

DAYS OF WEEK: ☐ SUN ☐ MON ☐ TUES ☐ WED ☐ THURS ☐ FRI ☐ SAT

TIME OF DAY: ☐ MORNING ☐ AFTERNOON ☐ EVENING

PREFERRED METHOD OF CONTACT: ☐ CELL PHONE ☐ HOME PHONE ☐ TEXT ☐ EMAIL ☐ ANY

NAME: _____

PART 2: DIAGNOSIS INFORMATION

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

TYPE OF OVARIAN CANCER: _____
(EXAMPLE: CLEAR CELL, GERM CELL, SEROUS CARCINOMA, ETC.)

ARE YOU CURRENTLY UNDERGOING TREATMENT? ☐ YES ☐ NO

TYPE OF TREATMENT: (PLEASE CHECK ALL THAT APPLY)

☐ SURGERY IF YES, DATE: _____/ _____/_____ TYPE: _____

☐ CHEMOTHERAPY IF YES. TYPE: ☐ INFUSION ☐ INTRAPERITONEAL ☐ ORAL

DID YOU HAVE CHEMOTHERAPY BEFORE SURGERY: YES ☐ NO ☐

DRUGS ADMINISTERED: _____

NUMBER OF TREATMENTS: _____

☐ RADIATION NUMBER OF TREATMENTS: _____

☐ CLINICAL TRIAL TYPE: _____

WHERE ARE YOU BEING TREATED: _____
(CANCER CENTER, HOSPITAL, PRIVATE DOCTOR)

TREATMENT DETAILS: (FREQUENCY OF TREATMENT, SIDE EFFECTS, ETC.)

_____

_____

_____

_____

SURGEON'S NAME: _____
FIRST LAST

LOCATION: _____

ONCOLOGIST'S NAME: _____
FIRST LAST

LOCATION: _____

NAME: _____

PART 3: MORE ABOUT YOU

PLEASE INDICATE WHICH OF THE FOLLOWING ARE CURRENTLY THE <u>MOST</u> STRESSFUL FOR YOU:

_____ CAREER/JOB _____ EMOTIONAL DISTRESS _____ FATIGUE _____ FEAR OF DEATH

_____ FEAR OF RECURRENCE _____ FERTILITY _____ FINANCES _____ NUTRITIONAL CONCERNS

_____ PARENTING _____ PHYSICAL CHANGES _____ RELATIONSHIPS _____ SEXUALITY _____ PET CARE

PLEASE INDICATE WHICH OF THE EMOTIONS YOU FELT AFTER YOUR DIAGNOSIS: (CHECK ALL THAT APPLY)

_____ ANXIETY/STRESS _____ DEPRESSION _____ FEAR/WORRY _____ GRATITUDE _____ DENIAL

_____ HOPE _____ SADNESS _____ GUILT _____ LONELINESS _____ ANGER

PLEASE INDICATE YOUR SUPPORT SYSTEM: (CHECK ALL THAT APPLY)

_____ SPOUSE/SIGNIFICANT OTHER _____ FRIENDS _____CHILDREN _____ SIBLINGS _____ PETS

_____ PARENTS _____FAITH _____OTHER PLEASE SPECIFY: _____

DO YOU SMOKE CIGARETTES: _____ DAILY _____ OCCASIONALLY _____ NOT AT ALL

IN WHAT WAYS DO YOU HOPE BEING PAIRED WITH A MENTOR MIGHT BE HELPFUL TO YOU?

_____

_____

_____

IS THERE ANYTHING ELSE YOU DO (PERSONALLY, PROFESSIONALLY, ETC.) OR OTHER INFORMATION YOU WOULD LIKE TO SHARE THAT MAY BE IMPORTANT WHEN CONNECTING TO A MENTOR?

_____

_____

_____

I HEREBY CONFIRM THAT THE INFORMATION PROVIDED IN THE ABOVE APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT PROVIDING FALSE INFORMATION MAY DISQUALIFY ME AS A PARTICIPANT IN THE WOMAN-TO-WOMAN PROGRAM. I WILL CONSIDER ALL INFORMATION THAT I GIVE AND GAIN IN THIS PROGRAM TO BE CONFIDENTIAL. I ALSO UNDERSTAND THAT MY PARTICIPATION MAY BE TERMINATED IF A BREACH OF CONFIDENTIALITY OCCURS.

PRINT NAME: _____

SIGNATURE: _____ **DATE:** _____

NAME OF EMERGENCY CONTACT: _____ **PHONE NUMBER:** _____

PLEASE SUBMIT YOUR APPLICAITION VIA EMAIL TO: KKURTZ@OVARIANCANCERPROJECT.ORG

OR YOU CAN MAIL YOUR APPLICATION TO:

OVARIAN CANCER PROJECT, P.O. BOX 1002, WILLIAMSVILLE, NY 14231 ATTN: KATHY KURTZ