

PEER SUPPORT REQUEST

Date _____

Name _____

Street Address _____

City, State, Zip _____

Email _____

Home Phone _____ **Cell** Phone: _____

Best time to call _____ Ok to leave message? Y or N

MATCHING INFORMATION

Year of Diagnosis: _____

Diagnosis (specific type and origin of cancer including stage)

Treatments (surgery, chemo, radiation):

Age: _____

Children at Home? Y or N Ages _____

CMC Patient? Y or N (If no, where are you receiving treatment? _____)

Please share your reasons for wanting to participate in the peer support program. Please describe any significant concerns or questions you would like to speak to a peer about.

I understand that information I share with my peer mentor will be kept confidential and I agree to keep all information that my peer mentor shares with me confidential.

Signature _____ Date _____