Breast Cancer Solutions

Mailing Address: 25422 Trabuco Road #105-167, Lake Forest, CA 92630-2797
866.960.9222 (phone) ◆ 866.781.6068 (fax) ◆ www.breastcancersolutions.org

PHYSICIAN'S REPORT

The individual listed below has requested assistance from Breast Cancer Solutions (BCS). **This form and a copy of the pathology report are required for this patient's application to be considered complete.** A signed release for the requested information is attached.

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SECTION I – TO BE COMPLETED BY APPLICANT	
Patient Name:	
Patient Date of Birth:	
Physician's Name:	Physician's phone:
Physician's Address:	Physician's fax:

SECTION II – TO BE COMPLETED BY PHYSICIAN – PLEASE PRINT CLEARLY			
Diagnosis:			
Stage:	Grade:	H2N Positive (circle): Y or N	Triple Negative (circle): Y or N
Date of diagnosis:		Date of last appointment:	

Planned Treatments		
Surgery (specify type)	Date of procedure	Expected recovery time
Chemotherapy (specify medications)	Start date	Expected end date
Herceptin	Start date	Expected end date
Radiation	Start date	Expected end date

Client's prognosis: ☐ Good ☐ Fair ☐ Guarded ☐ Other:	
Specific physical limitations:	
What level of employment activity is suitable for patient? ☐ Part-time ____ hours per week ☐ Full-time	
Projected date patient can return to work at pre-treatment level:	
Other prescribed medications:	
Comments:	
☐ **Copy of patient's pathology report is attached to this report** Physician's signature:	Date:

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