



Winning the fight against cancer, every day.®

Cancer Treatment Centers of America
at Western Regional Medical Center

Hospital and Physician History Form for New Patients

If you are interested in coming to Cancer Treatment Centers of America (CTCA) to receive an evaluation and a proposed treatment plan, we will need to collect your past medical records. The information we collect will allow us to review your medical records prior to your appointment at CTCA. This is necessary to provide you with a thorough medical evaluation from your CTCA treatment team.

Please complete this two-page form to provide us with important contact information from the specific hospitals and physicians with whom you have worked to receive your previous cancer treatment. Please include information from the time of diagnosis through the present time. We will use this information to request copies of your medical records from your providers.

Please complete this hospital and physician history form and immediately fax a copy to:

CTCA at Western Regional Medical Center at (623) 207-3358 or (623) 207-3359.

Page One

Patient name _____

1. Hospital where you have received cancer treatment:

Name _____

Address _____

Phone number _____

Physician's name _____

Please check the box that pertains to your treatment at this facility.

- | | | |
|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> X-ray, PET, CT, Bone Scans, Ultrasound or MRI | <input type="checkbox"/> Biopsy | <input type="checkbox"/> Radiation |
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Blood work | _____ |

2. Additional hospital where you have received cancer treatment:

Name _____

Address _____

Phone number _____

Physician's name _____

Please check the box that pertains to your treatment at this facility.

- | | | |
|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> X-ray, PET, CT, Bone Scans, Ultrasound or MRI | <input type="checkbox"/> Biopsy | <input type="checkbox"/> Radiation |
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Blood work | _____ |

3. Additional hospital where you have received cancer treatment:

Name _____

Address _____

Phone number _____

Physician's name _____

Please check the box that pertains to your treatment at this facility.

- | | | |
|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> X-ray, PET, CT, Bone Scans, Ultrasound or MRI | <input type="checkbox"/> Biopsy | <input type="checkbox"/> Radiation |
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Blood work | _____ |



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Page Two

Patient name

4. Oncologist office where you have received chemotherapy:

Name

Address

Phone number

Physician's name

5. Outpatient Center or Radiology Center where you have received scans:

Name

Address

Phone number

Physician's name

6. Hospital/Radiation Center where you have received radiation treatment:

Name

Address

Phone number

Physician's name

7. Additional facilities where you have received cancer treatment and/or other medical treatments, such as: mammograms, dialysis, mental health, cardiac, pulmonary, etc.

Name

Address

Phone number

Physician's name

Name

Address

Phone number

Physician's name

Name

Address

Phone number

Physician's name