

## Diagnosis Verification Form

Please provide to your oncologist to complete

*The Diagnosis Verification Form must be completed and signed by the treating physician*

The information requested below is necessary to complete the patient's application to the grant award.

Please send completed form to: John Estrella Foundation, 3 Seward Avenue, Beverly, MA 01915

**Applicant Patient Name:** \_\_\_\_\_ **Applicant date of birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

### **Treating Physician Information:**

Physician Name: \_\_\_\_\_

Facility/Practice Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Ext: \_\_\_\_\_ Fax: \_\_\_\_\_

Tax ID Number: \_\_\_\_\_

NPI Number: \_\_\_\_\_

Physician Email: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Office Contact Email: \_\_\_\_\_

### **Diagnosis and Treatment Information:**

Patient's Primary Diagnosis: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_

Began Treatment or will begin treatment on: \_\_\_\_\_

Ended Treatment or will end treatment on: \_\_\_\_\_

### **Physician Attestation:**

I attest that I have confirmed the patient's diagnosis and that all information supplied is complete, accurate, and supported in the patient's medical records. I understand this information is for the sole use of the John Estrella Foundation for Cancer Research, its representatives, and/or agents assigned to assess the patient's eligibility for participation in the Helping Hand Grant Program. I understand that application to and/or approval for the John Estrella Foundation for Cancer Research does not guarantee financial assistance.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_



THE JOHN ESTRELLA FOUNDATION FOR CANCER RESEARCH

3 Seward Avenue, Beverly, MA 01950 ~

<http://jestrellafoundation.org/>