Treating Physician's Report

Patient's name: _____ Age: _____ ☐ Male ☐ Female

_____ _____

Name of treating physician (please print) Signature of treating physician

1. Is this life threatening? ☐ Yes - ☐ No
2. Diagnosis and staging or extent of disease: _____

_____

- ☐ Is He/She undergoing treatment? – _____
- ☐ Is unresponsive to treatment? ☐ Is responsive to treatment _____
- ☐ No treatment at this time. _____

3. Does this child have a chance of attaining a cure? ☐ Yes - ☐ No
4. Estimated chance of surviving five years: ☐ 75% ☐ 50-75 ☐ 25-50% ☐ 25%
5. Current or planned treatment: _____

_____

6. Current functional status:
7. Is applicant ambulatory? ☐ Yes ☐ No – Special equipment or medication(s):_____

☐ Fully active with little or no symptoms.

☐ Moderate limitation of normal activity for a child of his/her age.

☐ Major limitation of activities or very symptomatic.

☐ Other – please explain: _____

8. How would expected side effects of treatment interfere with this child's function? _____

_____

_____

9. Additional remarks or comments: _____

_____