SURVIVORS OFFERING SUPPORT (SOS)

Anne Arundel Medical Center Breast Cancer Mentor Program

Medical Information for SOS Mentor

Date: _____

Name: _____ Birth Date: _____

Address: _____
Street City State/Zip Code

Phone Number(s): _____

Email Address: _____

Please specify (answer as much as you can):

Breast Cancer Surgery: Y/N ___ Type: _____Date:_____

Reconstruction: Y/N ___

Type of Reconstruction: Implant(s) ___ Latissimus Dorsi ___ Tissue Expander ___

Abdominal Flap ___ S-Flap ___ Free Tram ___ DEIP ___ Other _____

Treatment: Chemotherapy Y/N_____ Neo-adjuvant Chemotherapy Y/N_____

Chemotherapy drugs:_____

Herceptin Y/N_____ Other _____

Tamoxifen Y/N_____ Aromatase Inhibitors Y/N _____

Radiation Y/N_____

Accelerated Partial Breast Radiation _____ IORT Radiation _____

Whole Breast Radiation_____ Accelerated Whole Breast Radiation_____

Hobbies: _____

Any other info that would help in matching with a mentee:

_____

_____

_____

By signing below, I hereby consent to release of the above information in matching me with a mentee. Any additional information I provide is at my sole discretion and is not protected by Anne Arundel Medical Center.

Signature: _____ Print Name: _____

PLEASE return information to:

Anne Arundel Medical Center
Fortney Breast Center
Attention: Mentorship Coordinator
2000 Medical Parkway, Suite 200
Annapolis, MD 21401