PLEASE DO NOT SEND THIS TO THE METHODS CENTRE

Centre # [|] Patient # [| | |] Patient Initials [F | L]

PATIENT CONTACT FORM (1 of 2) - FORM L-1

In order to facilitate follow-up, it is important to collect contact information for you AND 2 alternate contacts that could assist us should you move during the course of the study. This information will not be given to anyone outside of the study.

Patient Contact Information

Patient:
(please print)

Last Name ______________________ First Name ______________________

Apt. No. ____ Street ______________________ Postal/Zip Code __________

Town/City __________ Province/State (if applicable) __________ Country __________

Home Phone # ______________________ Work Phone # ______________________

Family Physician Contact - Clinic Address

Physician:
(please print)

Last Name ______________________ First Name ______________________

Apt. No. ____ Street ______________________ Postal/Zip Code __________

Town/City __________ Province/State(if applicable) __________ Country __________

Phone # ______________________

Oncologic Surgeon Contact - Clinic Address

Surgeon:
(please print)

Last Name ______________________ First Name ______________________

Apt. No. ____ Street ______________________ Postal/Zip Code __________

Town/City __________ Province/State(if applicable) __________ Country __________

Phone # ______________________

PLEASE DO NOT SEND THIS TO THE METHODS CENTRE

Centre # ☐☐ Patient # ☐☐☐☐ Patient Initials ☐☐ F L

PATIENT CONTACT FORM (2 of 2) - FORM L-2

Referring Physician Contact - Clinic Address

Physician:
(please print)

Last Name ______ First Name ______

Apt. No. ______ Street ______ Postal/Zip Code ______

Town/City ______ Province/State(if applicable) ______ Country ______

Phone # ______

Alternate Contact Information

Contact #1:
(please print)

Last Name ______ First Names ______

Apt. No. ______ Street ______ Postal/Zip Code ______

Town/City ______ Province/State(if applicable) ______ Country ______

Home Phone # ______ Work Phone # ______

Relationship to Patient: ______

Contact #2:
(please print)

Last Name ______ First Names ______

Apt. No. ______ Street ______ Postal/Zip Code ______

Town/City ______ Province/State(if applicable) ______ Country ______

Home Phone # ______ Work Phone # ______

Relationship to Patient: ______