American Childhood Cancer Organization Inland Northwest (ACCOIN)
Affiliate of American Childhood Cancer Organization (ACCO)
P.O. Box 8031, Spokane, WA 99203 (509) 474-2759
www.acco.org/inlandnw

CONFIRMATION OF DIAGNOSIS

Today's Date _____

To be completed by child's parent/guardian:

Child's Name _____ Date of Birth _____

Diagnosis _____ Date of Diagnosis _____

Oncologist Name _____ Oncologist Phone # _____

Address _____ Fax # _____

Parent or Guardian _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

I hereby authorize my child's treating oncologist or medical team to confirm with ACCOIN my child's diagnosis and/or current condition for the purpose of assisting my child and family. This is not a request for medical records.

Signature of Parent/Guardian_____

Printed Name and relationship of signer_____

Signature of Patient if over 18 years old_____

To be completed by treating oncologist:

Child's Name _____

Diagnosis _____ Date of Diagnosis _____

Currently receiving chemotherapy or radiation: Yes No

If Yes, projected end date: _____

Other information to help us serve this family better: _____

_____

Signature of Physician or Representative _____

Printed Name _____ Date _____

Title _____