THE UNIVERSITY OF TEXAS
MD ANDERSON
CANCER CENTER
Making Cancer History®

CLINICAL TRIALS REQUEST FORM

From: _____

Phone: _____ **Fax:** _____

You'll hear from us within 48 hours with the status of your request (excluding weekends and holidays).

Patient name_____ **Gender**_____ **Date of birth**_____

Diagnosis_____ **Date of diagnosis** _____

Histology_____

Stage _____ **Metastasis** _____

Current status _____

Other medical conditions _____

_____

Breast:
Path report: ER_____ **PR**_____**; Her-2/neu: IHC**_____ **or FISH**_____**; Nuclear Gr.** _____

Prostate ca:
Hormonal status: _____ **PSA**_____ **Date started:** _____

Previous Treatments

Surgery _____ **Date** _____

Surgery _____ **Date** _____

Chemotherapy _____

Date received _____ **Date completed** _____ **Number of courses**_____

Chemotherapy _____

Date received _____ **Date completed** _____ **Number of courses**_____

Chemotherapy _____

Date received _____ **Date completed** _____ **Number of courses**_____

XRT (area) _____ **Doses** _____

Date received_____ **Date completed** _____

Comments_____

OFFICE OF PHYSICIAN RELATIONS
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