

# Cancer Buddy Network Questionnaire



Newly diagnosed seeking buddy: \_\_\_\_\_

Cancer survivor volunteering to be a buddy: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Referred by: \_\_\_\_\_

Address\*: \_\_\_\_\_ Email: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

Stage (please circle as appropriate): 0 (early) 1 2 3 4 recurrence? \_\_\_\_\_

Please describe any screening procedure you received (e.g. needle biopsy, CAT scan, PET, MRI): \_\_\_\_\_

## Treatment:

Please check and describe the treatment(s) you received:

\_\_\_\_surgery \_\_\_\_\_

\_\_\_\_chemotherapy (drug regimen) \_\_\_\_\_

\_\_\_\_radiation \_\_\_\_ bone marrow transplant \_\_\_\_ drug/hormone therapy \_\_\_\_\_

\_\_\_\_other \_\_\_\_\_

If you had breast cancer, was there reconstruction? \_\_\_\_ If yes, what kind?  
\_\_\_\_ Same time as mastectomy? \_\_\_\_\_

Where were you treated? \_\_\_\_\_

By whom were you treated? \_\_\_\_\_

Please describe any complementary treatments (e.g. acupuncture, massage, herbs)  
you received: \_\_\_\_\_

## Personal Information

What was your age when you were diagnosed? \_\_\_\_\_ Age now \_\_\_\_\_

Were you pregnant or primary caregiver of children at the time of diagnosis? \_\_\_\_

Were you working when you were diagnosed? \_\_\_\_ Are you working now? \_\_\_\_\_

Do you have insurance? What type? \_\_\_\_\_

Have you ever been or are you now in a support group? \_\_\_\_\_

## Satisfaction Survey

Were you satisfied with the treatment you received? Please explain \_\_\_\_\_

\_\_\_\_\_

Were you satisfied with the place where you were treated? \_\_\_\_\_

How do you feel about any complementary treatment(s) you received? \_\_\_\_\_

\_\_\_\_\_

If you are/were in a support group, did you find that helpful? \_\_\_\_\_

**Option**

**Waiver:** I give permission for Cancer Library personnel to give my name and phone number or email address and cancer diagnosis to appropriate patients using the Cancer Buddy Referral Service.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**OR** I request Cancer Library Personnel to call me and give the name and phone number of a patient who would like to talk with me. I will call the patient.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I understand my role as a peer resource in the Buddy Referral Service is to share my experience with cancer and cancer treatment. I will not give medical advice or make medical treatment recommendations. I understand medical decisions are the responsibility of the patient and his/her physicians.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

*Sometimes callers prefer to talk with someone of the same ethnic background, sexual orientation, gender identity, age, and or spiritual orientation. If you are comfortable sharing this information, please tell us anything you would like us to tell callers about you.*

Ethnic/racial background

Sexual Orientation/Preference

Gender Identity

Spiritual Orientation

Age

Languages, other than English?

Do you have any strong feelings about what causes cancer?

Anything else you would like to add?

**Thank you for your willingness to participate in the Cancer Buddy Network. Please return your completed application to Memorial's Cancer Library, 3555 Round Barn Circle, Santa Rosa, CA 95403. Upon receiving your completed application, we will be in touch with you.**

\*We will not give anyone your address. We request it for internal use only.