Life Raft Group Membership Application

All information provided will be kept strictly confidential and is for the Life Raft Group only. We are committed to protecting the privacy of our members. Any data or information that we share in any way is always cleansed of identifying information in to protect confidentiality.
***If you have any immediate needs or questions please call us at 973-837-9092 (9a.m.-5p.m. EST)**

General Information

Name: ____

Patient's Name (if different): __________________________________

Relationship to patient: ______________________________________

Home Address: ____

City, State, Zip: ____

Country: ____

Phone: ____

Fax: ____

Email: ____

Back-up Email: ____

How did you find us?: (Circle one)
LRG Member Internet Doctor

Patient Information: ____

Date of birth: ____

Birthplace: (City, State, Country): ________________________________

Marital Status: (Circle one)
Single Married Divorced Widowed Separated Other

Sex: (Circle one)
Female Male

Treatment

Gleevec Start Date: ____

Initial Dosage:____

Current Dosage: ____

Reason for altering dosage if changed: ____________________________

Other Medications

Other Medication Name: ______________________________________

Other Medication Dosage: _____________________________________

Other Medication Start Date: ___________________________________

Other Medication Name: ______________________________________

Other Medication Dosage: _____________________________________

Other Medication Start Date: ___________________________________

Other Medication Name: ______________________________________

Other Medication Dosage: _____________________________________

Other Medication Start Date: ___________________________________

All GIST diagnoses must be confirmed by a CKit (or CD117) test. These results can be found on your pathology report. If you do not have them, please request a copy of your pathology report and send the results as soon as possible.

Test Date: ____

CKit Results:____

Date first tumor was found:____________________________________

Initial Diagnosis: (Circle one)
GIST Other: ____________________ (If other please describe in comments)

Initial Diagnosis Comments:

____

____

____

____

____

Primary Tumor Location & Treatment:

____

____

____

____

____

Please indicate dates, site and treatments for any recurrences:

____

____

____

____

____

Other Medical Remarks:

____

____

____

____

____

Are you participating in a clinical trial? (Circle one)
Yes No

If yes, please provide the following information:

Trial Site: ____

Trial Doctor: ____

Trial Doctor's Email: ____

Trial Doctor's Phone: ____

Trial City: ____

Trial State: ____

Trial Country: ____

If no, please provide your doctors information. We will add them to our newsletter mailing list and send them educational materials if they are not already in the LRG network.

Doctor: ____

Facility: ____

Mailing Address: ____

City: ____

State: ____

Country: ____

Doctor's Email: ____

Doctor's Phone: ____

Please tell us something about yourself professionally and/or personally:

____

____

____

____

____

____

Remarks:

____

____

____

____

____

____