BREAST CANCER LETTER OF DIAGNOSIS FOR:

<table>
<tr>
<td>Project Open Hand-
Nutritional Services
730 Polk Street
San Francisco, CA 94109
San Francisco Ph: 415-447-2326
San Francisco Fax: 415-447-2492
Oakland Ph: 510-622-0221
Oakland Fax: 510-452-1061
 </td>
<td>Shanti's
LifeLines Breast Cancer
Program
730 Polk Street, 3rd Floor
San Francisco, CA 94109
Ph: 415-674-4780
Fax: 415-674-0370
 </td>
<td>Breast Cancer
Emergency Fund
12 Grace Street
San Francisco,
CA 94103
Ph: 415-558-6999
(ext. 8)
Fax: 415-558-6990
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Client Name:	**Date of Birth:**

CLIENT CONSENT TO RELEASE INFORMATION

(All certificates are subject to verification. Fraudulent documentation may lead to termination of services.)

I authorize my medical provider to release information about my medical condition for purposes of verifying my eligibility to the agencies listed above:

Client Signature:	**Date:**

PROVIDER VERIFICATION OF STATUS-to be filled out entirely by medical provider

Date of breast cancer diagnosis: **Month** ________________ **Year** ________________
Clinical Stage: **Currently Unknown→☐** **DCIS→☐** **I→☐** **II→☐** **III→☐** **IV→☐** **Other**______________
Date of most recent surgery: **Month** ________________ **Year** ________________
Surgery Type: **Biopsy→☐** **Lumpectomy→☐** **Mastectomy→☐** **Reconstructive→☐**
Most recent hospitalization: **Month** ________________ **Year** ________________
Current Treatment: **Radiation→☐** **Chemotherapy→☐** **Hormonal Therapy→☐** **Other**______________
Date current treatment began on: **Month** ________________ **Year** ________________
Current medications prescribed for breast cancer-related conditions: ______________________________
Current side effects from breast cancer treatments: ______________________________
How do the above treatments affect patient's ADL (Activities of Daily Living): **None→☐** **Mildly→☐** **Moderately→☐** **Severely→☐** **Notes**______________________________
Additional Comments: ______________________________

NOTE: Re-Certification is required at regular Intervals

My signature certifies that I am the Medical Provider for the above named client, who:

- Has a breast cancer diagnosis; **and**
- Has the indicated conditions/symptoms and/or extenuating circumstances.

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Signature of Physician/Nurse Practitioner/PA/RN **Phone & Fax Number** **Date**

Version: 1/21/2009

BREAST CANCER LETTER OF DIAGNOSIS FOR:

Office stamp w/ address required here **Printed Name of Provider**