Patient Feedback Form

All questions marked with an asterisk (*) are required.

Your Name: *

Matched With: *

Date: (mm/dd/yyyy) *

Method of Contact: *

- [ ] Phone
- [ ] Email
- [ ] Other:

Date(s) of Contact: *

Length of Contact: *

Your Coping with Cancer Diagnosis: *

- [ ] Poor
- [ ] Fair
- [ ] Okay
- [ ] Excellent

Are there any issues that need further examining (counseling, financial, family, insurance)?

Do you plan on maintaining any further contact with your Mentor? *

- [ ] Yes
- [ ] No
- [ ] As Needed

Overall match was: *

- [ ] Poor
- [ ] Fair
- [ ] Okay
- [ ] Good
- [ ] Excellent

Once our patients are 6 months post-treatment, they are able to volunteer as a 4th Angel. If this interests you, may we contact you in 3 – 6 months?

- [ ] Yes
- [ ] No
- [ ] Unsure at this time

How did you hear of our program:

- ☐ Brochure
- ☐ Internet
- ☐ Physician
- ☐ Cancer Organization
- ☐ Other
- ☐ Social Worker
- ☐ Nurse
- ☐ Radio/TV/Newspaper
- ☐ Family/Friends

Would you recommend the 4th Angel Program to others?

- ☐ Yes
- ☐ No

We also have a 4th Angel Caregiver Mentor Program. Would your caregiver (spouse, child, parent, sibling, partner) be interested in becoming a Caregiver Mentor?

- ☐ Yes
- ☐ No

If yes, please provide their contact information:

Recommendations/Questions for the 4th Angel Program Coordinator.