



## 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 4<sup>th</sup> 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:

- |  |   |
|--|---|
| <input type="checkbox"/> Brochure            | <input type="checkbox"/> Social Worker      |
| <input type="checkbox"/> Internet            | <input type="checkbox"/> Nurse              |
| <input type="checkbox"/> Physician           | <input type="checkbox"/> Radio/TV/Newspaper |
| <input type="checkbox"/> Cancer Organization | <input type="checkbox"/> Family/Friends     |

Other

Would you recommend the 4<sup>th</sup> Angel Program to others?

- Yes  
 No

We also have a 4<sup>th</sup> 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 4<sup>th</sup> Angel Program Coordinator.