

Subject:

Patient and Family Library Search Request Form

Requestor Information: *(Please print clearly)*

Name: _____	Date: _____
Tel: _____	How will the information be picked up:
Email: _____	<input type="checkbox"/> Library pick-up
You are a: <input type="checkbox"/> Patient	<input type="checkbox"/> Email
<input type="checkbox"/> Family Member	<input type="checkbox"/> Mailing
<input type="checkbox"/> Other	Address: _____

Date Needed: _____	

Search Information

What is the **primary** cancer diagnosis:

- | | |
|--|---|
| <input type="checkbox"/> Brain Tumor | <input type="checkbox"/> Blood Cancer |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Hodgkin's Lymphoma |
| <input type="checkbox"/> Gastrointestinal Cancer | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Colorectal Cancer | <input type="checkbox"/> Non-Hodgkin's Lymphoma |
| <input type="checkbox"/> Pancreatic Cancer | <input type="checkbox"/> Multiple Myeloma |
| <input type="checkbox"/> Rectal/Anal | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Genital-Urinary Cancer | <input type="checkbox"/> Sarcoma |
| <input type="checkbox"/> Bladder Cancer | Type: <input type="checkbox"/> Soft Tissue |
| <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Bone _____ |
| <input type="checkbox"/> Testicular | <input type="checkbox"/> Melanoma _____ |
| <input type="checkbox"/> Gynecological Cancer | <input type="checkbox"/> Neuroendocrine : _____ |
| <input type="checkbox"/> Cervical Cancer | |
| <input type="checkbox"/> Ovarian Cancer | |
| <input type="checkbox"/> Uterine Cancer | |
| <input type="checkbox"/> Vaginal | |
| <input type="checkbox"/> Head and Neck Cancer | What part of the body is affected? (if relevant): |
| <input type="checkbox"/> Lip and Mouth Cancer | _____ |
| <input type="checkbox"/> Cancer of the Larynx | |
| <input type="checkbox"/> Cancer of the Nasopharynx | |
| <input type="checkbox"/> Cancer of the Oropharynx | |
| <input type="checkbox"/> Cancer of the Hypopharynx | |
| <input type="checkbox"/> Paranasal Sinuses and Nasal Cavity Cancer | |
| <input type="checkbox"/> Salivary Glands Cancer | |
| <input type="checkbox"/> Thyroid Cancer | |
| <input type="checkbox"/> Lung Cancer | |

What is the type of treatment you are receiving:

- Surgery
- Chemotherapy
- Radiation therapy
- Immunotherapy
- Don't know

Phase of Treatment

- Haven't started treatment
- Just starting treatment
- Half way through treatment
- Finishing treatment
- Don't know

Type of Information Requested

- General disease related information
- General treatment information (e.g. chemotherapy; radiation therapy; surgery)
- Specific treatment information (e.g. type of chemotherapy/ radiation therapy; side effects; preparation; alternative therapies; complementary therapies)
- Clinical trial / Research Study information (e.g. what are clinical trials)

Specific Question(s) and or Keywords

This section to be completed by Library Staff

Staff Name: _____ **Date:** _____

1. Before going on the Internet, I have checked to see if any existing library sources can answer this question?

- Library Catalogue, UHN YouTube, E-books, UHN pamphlets
- UHN Public Website

2. Information taken from the internet is from a reliable source such as:

- OncoLink
- Cancer.gov
- Canadian Cancer Society
- A web site that is listed on the General Cancer Websites List D-5475

3. What information has been given to the patient or family member:

Staff /Volunteer Signature _____