UNIVERSITY OF COLORADO HOSPITAL
THE CENTER FOR
INTEGRATIVE MEDICINE

COMPLEMENTARY CANCER SUPPORT FUNDING PROGRAM APPLICATION

PATIENT INFORMATION

Name:_____ Date of Birth:_____

Address:_____

City:_____ State: _____ Zip:_____

Primary Phone Number:_____ Is it ok to leave a message at this number regarding your application? Y / N

DIAGNOSIS & SYMPTOMS

What type of cancer were you diagnosed with? _____

Name of your oncologist: _____

Are you currently receiving chemotherapy, radiation, or after-treatment preventive medication? Y / N

If so, please describe:_____

Have you had surgery as part of your cancer treatment? Y / N

If so, please describe: _____

What symptoms are you experiencing that you would like to address with complementary therapies? _____

_____

Please return this completed application to The Center for Integrative Medicine, attention Practice Manager, by bringing it to the front desk of the clinic on the 5th floor of the Anschutz Outpatient Pavilion or by mailing it to:
1635 Aurora Court., Mail Stop F743
Aurora, CO 80045
Please call the clinic at 720-848-1090 with any questions.

TREATMENT OPTIONS

If your physician indicates it is safe for you to have both massage and acupuncture, please review page 3 of the information form, which gives information about how therapies can help you, and then indicate your preferences below for your 6 no-cost visits:

- ☐ 6 massage visits
- ☐ 6 acupuncture visits
- ☐ 1 massage visit, 5 acupuncture visits
- ☐ 2 massage, 4 acupuncture visits
- ☐ 3 massage, 3 acupuncture visits
- ☐ 4 massage, 2 acupuncture visits
- ☐ 5 massage, 1 acupuncture visit

*Please note that if your physician only signs off on one modality, all six of your visits will be the specific therapy that your physician approves.

Complementary therapies are generally safe and non-invasive therapies to be done in conjunction with conventional treatment in an effort to minimize or alleviate side effects from treatment, improve quality of life, and help to prevent toxicity.

Our therapists are experienced in treating patients with cancer and are knowledgeable in modifications they need to make based on the patient situation, stage of treatment, surgical status, medications, etc. Here are some examples of common concerns or issues:

CONDITION	PROBLEM(S)	MODIFICATION
Bleeding problem (low platelets, easy bruising, on a prescription blood thinner like Coumadin, or taking other supplements that can increase bleeding risk, like garlic, ginseng, ginkgo, vitamin E, ginger, and aspirin	1. Bruising with massage 2. Bruising with acupuncture	1. Tell the massage therapist, who can use a lighter touch 2. Tell the acupuncturist; acupuncture doesn't need to be changed
Immune system compromise (low WBC count from chemotherapy, certain chemotherapy medications or steroids)	Higher risk for infection	Tell all providers, no modifications necessary as proper sanitization is practiced throughout the clinic
Cancer metastatic to bones or very weak bones	Fracture with massage	Tell the massage therapist, who will use a lighter touch

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PHYSICIAN AUTHORIZATION – TO BE COMPLETED BY THE TREATING ONCOLOGIST

Do you have any concerns pertaining to your patient receiving massage or acupuncture? Y / N

Any particular modifications you recommend? Y / N

If so, please describe:_____

_____

Please indicate which services you feel are safe for your patient to utilize by initialing next to the approved service(s) below:

Acupuncture _____ Massage _____

Do you have any additional comments, concerns, or things you feel we should be aware of? In addition to listing below, please feel free to contact our medical director, Dr. Lisa Corbin, through a staff message in EPIC.

_____

_____

_____

_____

ACKNOWLEDGEMENTS

My patient is safe to seek the complementary therapies I indicated above:

Physician Signature: _____ Date:_____

I have read and understand the informational packet regarding the fund program and the recommended therapies for my symptoms. I understand that funding is not guaranteed and is based upon applicant qualifications and availability of funds.

Patient Signature: _____ Date:_____

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