Doctor's Questionnaire

Seeds of Hope
Inspiring Youth-Encouraging Families

Patient's Name with illness _____

Date of Diagnosis _____/_____/_____

Diagnosis Medical Issue: [please include Stage or Grade] _____

_____

_____

_____

_____

_____

Prognosis Medical Issue: _____

_____

_____

_____

_____

Treatment Plan: _____

_____

_____

_____

_____

In your opinion, has this illness impacted the patient's daily life? _____

_____

_____

Doctor's Signature: _____ Date _____/_____/_____

Clinic: _____

Thank you for sending a Doctor's Questionnaire to Seeds of Hope by Email, Mail or Drop-off to one of the following contacts:

For Seeds of Hope in Oregon:
Email: *info@SeedsofHopeCares.org*
Phone: *503-434-1730 ask for Carmen*
"See Ya Later" Foundation/Seeds of Hope
1016 NW Adams St. / P.O. Box 1281
McMinnville, OR 97128

For Seeds of Hope in Washington:
Email: *info@SeedsofHopeCares.org*
Phone: *253-332-1126 ask for Stephanie*
"See Ya Later" Foundation/Seeds of Hope
204 E Main St.- Auburn, WA 98002
P.O. Box 8 - Auburn, WA 980