62 Rosalino Street, Woodbrook,
P.O.S., Trinidad and Tobago
1-800-TTCS(8827) • (868)-622-6827
ttcancersociety.org

RBC/RBTT Caribbean Children's Cancer Fund

7-9 St. Clair Avenue, Port-of-Spain, Trinidad, W.I.
Telephone: (868) 625-7288 • Ext: 80302
Email: tt-info@rbc.com

PATIENT INFORMATION FORM

To be completed by Parent/Legal Guardian Please circle US$ or TT$ where indicated below to identify currency (Please print in block letters)

PATIENT DEMOGRAPHIC

Last Name	First Name	Middle Name
Application Date	Date of Birth (DD/MM/YYYY)	Sex: Male ☐ Female ☐

Residential Address

Street	
Town/City/Parish	Country

PARENT/LEGAL GUARDIAN INFORMATION

Last Name	First Name	Relationship to Patient

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Residential Address

Street	
Town/City/Parish	Country

Occupation	Name of Employer	Employer's Address

Contact Details

Tel. Work	Mobile	Tel. Home	Email

PATIENT INFORMATION

Diagnosis	Date of Diagnosis	Original Diagnosis or Recurrence

If this is a recurrence, what was the date of original diagnosis?

Physician's Name	Physician's Address	Physician's Phone Contact(s)

TREATMENT INFORMATION

Are you currently receiving treatment Yes ☐ No ☐	If *Yes*, Name of Treatment Centre

Cost of Treatment US$/TT$	If *No*, Expected Treatment Centre	Estimated Cost of Treatment US/TT$

Amount to be funded by self US$/TT$	Amount to be funded by fundraising activities US$/TT$	Amount to be funded by insurance US$/TT$	Funds requested US$/TT$

CONFIDENTIALITY DISCLAIMER

RBC Royal Bank and The Trinidad & Tobago Cancer Society regard all health information as confidential. Personal information will only be provided to authorised individuals to assess your diagnosis and funding qualification.

MEDICAL DISCLAIMER

Please note that the TTCS does not provide medical services and does not accept responsibility for the medical care of patients. Patients remain under the care of their primary physician/s and it is important that parents continue to report all medical issues to their respective physician/s. The undersigned hereby certifies that all information provided in this application is true, complete and correct and acknowledges that such information will be used by the TTCS to determine the undersigned's eligibility for funding.

Parent/Legal Guardian Signature: _____ Date: _____

The TTCS gives no guarantee that applicants will be successful in receiving funding. Please note that the decision given as to the status of your application is final and binding.