

Yoga-oncology Registration Form

Eligibility criteria

To be eligible, you must meet one of these two criteria:

- 1) Have been diagnosed with breast cancer in the past 36 months (3 years),
or
- 2) Have metastatic breast cancer (Stage 4)

Your personal information

Last name: First name:

Address:

City: Postal code: Home phone:

Mobile phone: Email:

Your medical information

1. Date of your most recent diagnosis or recurrence of breast cancer:

2. Current stage of breast cancer:

3. Actual or planned date of first treatment:

3.1. What's is the first treatment you received/will receive?

4. Are you receiving hormone therapy? Yes No Soon

4.1. If you answered "yes" to the previous question, please indicate the actual or planned date of the first hormone therapy treatment:

5. Did you finish all your treatments? Yes No

5.1. Actual or planned date of the end of treatment:

5.2. What was the last treatment you received/will receive?

*****MANDATORY*****

Your healthcare professional (oncologist, surgeon, radiation oncologist, pivot nurse, social worker or family physician) must fill out and sign this section.

Professional's full name:	<input type="text"/>	Title:	<input type="text"/>
Institution:	<input type="text"/>		
Phone number:	<input type="text"/>	Ext.:	<input type="text"/>
Email:	<input type="text"/>		
Signature:	<input type="text"/>	Date	<input type="text"/>

In signing, I certify that the information provided above is correct.

Disclaimer and signature

I, the undersigned, hereby confirm my wish to take the yoga classes paid for by the Quebec Breast Cancer Foundation.

I understand that:

- it is my responsibility to consult my doctor and inform him/her of my participation in a physical activity program, and
- there are risks associated with physical activity; I therefore take responsibility to inform the appropriate persons of my physical condition and any discomfort I may feel, and to modify, reduce or terminate my participation if necessary, according to opinion and advice of the appropriate persons;
- discomfort, pain, weakness, fatigue, calf cramps, chest pain, nausea, change in blood pressure are all possible results of yoga practice, and I fully assume this risk.

Furthermore, I will notify the yoga teacher of any pain, discomfort, fatigue or other abnormal symptoms before, during and after the class.

I release the QBCF and its representatives of all liabilities, and thereby waive all actions, causes of action, demands, recourses, proceedings, claims or damages or any liability of any kind that may arise now or in the future, directly or indirectly related to my participation in activities funded by the Quebec Breast Cancer Foundation, and including damages, injuries or accidents to myself.

I certify that the above information is accurate and complete. I acknowledge that the content of this document shall be used exclusively to create my file so that the Quebec Breast Cancer Foundation can help me. I understand that anonymized data will be used for statistical purposes.

I am aware that fraudulent requests could result in legal action.

For verification purposes, I authorize the Quebec Breast Cancer Foundation to discuss my file with my medical team.

I understand that the Quebec Breast Cancer Foundation reserves the right to refuse any request for any reason it deems reasonable, such as available budget or other facts related to my situation.

Signature:	<input type="text"/>	Date	<input type="text"/>
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****Once you have filled out and signed this form, please return it to the yoga studio with a copy of your photo ID.**