Chordoma Emergency Health Information

CHORDOMA FOUNDATION

Type directly in the blue fields below, or print first and then complete.

Personal information

Full name	Date of birth
Date of chordoma diagnosis	

Location of original tumor

- ☐ Skull base (clival)
- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar
- ☐ Sacral

Metastatic: ▢ Yes ▢ No

Location(s):

Type of chordoma

- ☐ Conventional/chondroid
- ☐ Poorly differentiated
- ☐ Dedifferentiated
- ☐ I don't know

Physician information

Primary Care Provider

Doctor's name

Clinic

Phone

Email

Should this doctor be contacted in the event of a medical emergency? ▢ Yes ▢ No

Chordoma care provider

Doctor's name

Institution

Phone

Email

Should this doctor be contacted in the event of a medical emergency? ▢ Yes ▢ No

Treatment history (include brief details, dates, etc.)

Surgery:

Radiation:
Systemic therapy/ Clinical trials: Are you currently on systemic therapy? ▢ Yes ▢ No If yes, include details:
Current health status (side effects from treatment, areas of tumor that might be growing, other health challenges you experience, etc.)
Current medications (name, dose, when taken)
Other important information (allergies, preferences, etc.)