

**THE PROHASKA MEDICAL
FINANCIAL ASSISTANCE FUND**

*** To be filled out by your physician, or licensed Speech/Language Pathologist.**

Your patient _____ has applied to the International Association of Laryngectomees for financial assistance for needs related to head and neck cancer. In order to review that application we need the following information for which the patient has signed the enclosed Release of Information:

1. Date of cancer diagnosis? _____
Diagnosis? _____

2. Recommended treatment _____
Is the patient currently in treatment? _____
Has the treatment been completed? _____

3. What is the prognosis? _____

4. Is the patient currently receiving speech therapy? _____
Is additional therapy indicated? _____

5. Does the patient currently have a means of verbal communication?

6. If not, is an artificial larynx needed for communication?

Health Care Provider

Date

Please return this form **postmarked no later than June 30, 2008** to:
Prohaska Medical Financial Assistance Fund, Assessment Review Committee,
c/o International Association of Laryngectomees,
Terrie Hall, 4167 Hwy. 150 N., Lexington, NC 27295-7248.
Email: Terrie Hall <tlh_tfsnc2002@yahoo.com>
Fax: 336-732-3167
Phone: 336-731-3635