Cushing's Support & Research Foundation Membership Application

*Patient's Name____Date___________

*Address ____

*City, State, Zip ____

*Country:_____________

Home Phone_______________________ **E-Mail**________________________

***Full Membership Level**

❑ Member $30 ❑ Friend $50 ❑ Sponsor $100 ❑ Donor $500 ❑ Benefactor $1,000

❑ I would like to join, but cannot afford payment at this time

*Are you a: ❑ Patient ❑ Parent (your name______________________)

❑ Other Family Member ❑ Other____________

Please Note: Providing further information on this form indicates that you have read and accept the CSRF privacy policy that is available at www.CSRF.net

*May the CSRF send you emails? ☐ yes ☐ no

*May the CSRF provide your name and phone number to patients that contact us? ❑ yes ❑ no

*May the CSRF provide your email to patients that contact us? ❑ yes ❑ no ❑ don't have email

*Would you like your name, city, state, tumor location, phone and email listed in our next newsletter so others may contact you? ❑ yes email ☐ yes email ❑ no

*Would you like to receive group emails from other members through our web site? ❑ yes ❑ no

♦♦

patient info ↓

Date of Birth___________________ Gender (circle one) Male Female

Occupation (please circle: current of former) _________________

*Tumor Location/Source

❑ Pituitary ❑ Adrenal tumor – one gland ❑ Bilateral Adrenal Disease

❑ Not yet diagnosed with Cushing's ❑ Still undergoing testing to determine source

❑ Ectopic: lung, pancreas, unknown, other

❑ Steroid induced from ______________ (cream, injections, etc.)

Age at Diagnosis____________________

Month/Year Diagnosed_______________

How long did you have Cushing's before diagnosis?____________________(ys)

How many physicians did you see before diagnosis?____________________

Who originally suggested Cushing's as your diagnosis? (physician, endocrinologist, self, friend)________________

♦♦

Have you had:

Transsphenoidal surgery: ❑ yes ❑ no When___________ Where________________________

Adrenalectomy: ❑ Unilateral or ❑ Bilateral When________Where___________________________

By Laparoscopy?______

Radiation: ❑Traditional ❑Gamma knife ❑Lineac ☐Proton Beam

When_____________________ Where?__________________________________

Have you had a pituitary tumor recurrence? ___yes ____no

Have you had a second pituitary surgery ? ❑ yes ❑ no When__________ Where_______________

Have you ever taken medications used to treat Cushings?

☐Ketoconazole ☐Korylm ☐Signifor ☐Other __________________ ☐No

♦♦

How did you hear about the CSRF?

What would you like the CSRF to do for you?

Please mail to: CSRF, 60 Robbins Rd. #12, Plymouth, MA 02360