

***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](http://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

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 \_\_\_\_\_

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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?