Please email this completed form to Mandy Boes at mandyboes@truenorthtreks.org

Cancer Survivor Medical Form

Background History for the Medical Professional

True North Treks (TNT) courses are backcountry wilderness expeditions for young adult cancer survivors and their caregivers, and can last upwards of 1 week. TNT courses are usually only offered during summer and fall months; however, participants could still be faced with challenging weather conditions including storms, high winds, intense sunlight and insects. Physical demands on the applicant may include carrying a backpack weighing upwards of 40 pounds over uneven terrain, ascending and descending steep surfaces, and/or canoeing in rivers with strong currents. Elevations for some courses range from sea level to 10,000 feet. Participants will sleep outdoors in tents and protected shelters and will spend the majority of days hiking, backpacking and/or canoeing. They will set up their own camp and prepare their own meals. Because some TNT participants may be immuno-compromised, appropriate water purification methods (e.g., boiling, filters) will be used to prevent cryptosporidium.

The current medical status and health history of our applicants can add to the potential for adverse health reactions. Although trek leaders are trained as wilderness first responders, have established contacts with local medical personnel and utilize satellite phones for medical evacuation purposes, because TNT operates in remote areas, such evacuation to modern medical facilities could potentially be delayed depending on the circumstances. That said, participant safety is our first priority, and everything will be done to assure the safety, health and well-being of TNT participants. Members of our medical team represent disciplines of medical oncology, nursing, integrative medicine, emergency medicine, social work and clinical psychology. All applications are reviewed by one or more members of this team prior to acceptance.

TNT is not a correctional, behavioral or rehabilitation program and is not a place to quit smoking, drinking or drugs or to work through behavioral or psychological problems. We ask that participants refrain from tobacco use, substance use or unsafe behaviors or they will risk expulsion from the trek at their own expense. Prior physical conditioning and an enthusiastic mental attitude are prerequisites. Each participant is expected to take good care of him or herself.

In the interest of the personal safety of both the applicant and the other trek members, please consider the questions carefully when completing the heath form. If we have any question on the applicant's capacity to successfully complete the course we well call him or her to discuss it.

Cancer Survivor Applicant Information

First Name *

Last Name *

Birth Date * (mm/dd/yyyy)

Medical Provider Information

First Name *

Last Name *

Profession/Discipline *

Phone *

Email *

Applicant's Cancer History

Primary site or type of the applicant's cancer *

Did the cancer spread to other parts of the applicant's body? *

- Yes
- No

If yes, please explain the locations to which it spread.

Did the applicant experience a cancer recurrence? *

- Yes
- No

If yes, please write the date and location of the most recent recurrence.

Is the applicant currently in remission? *

- Yes
- No

Applicant's Cancer Treatment History

SURGICAL TREATMENT

Did the applicant have surgical treatments in the past? *

- Yes
- No

If yes, please write the date and type of past surgeries.

Is the applicant currently scheduling a surgical treatment? *

- Yes
- No

If yes, please write the date and type of surgery as well as any complications.

CHEMOTHERAPY TREATMENT

Did the applicant receive chemotherapy treatments in the past? *

- Yes
- No

If yes, please list the dates and medications of past chemotherapy treatments.

Is the applicant currently receiving chemotherapy treatment? *

- Yes
- No

If yes, please write the date(s) and medication(s) of the current chemotherapy.

Is the applicant currently taking any myelosuppressive preventative therapy? *

- Yes
- No

If yes, please describe this therapy

Is the applicant currently or have they ever been bothered by or experienced any complications related to chemotherapy? *

- Yes
- No

If yes, please describe the chemotherapy-related complications.

RADIATION THERAPY

Did the applicant receive radiation therapy in the past? *

- Yes
- No

If yes, please write the date(s) and location(s) of the past radiation therapy.

Is the applicant currently receiving or recovering from radiation therapy? *

- Yes
- No

If yes, please write the date(s) and location(s) of the current radiation therapy.

Is the applicant currently or have they ever been bothered by or experienced any complications related to radiation therapy? *

- Yes
- No

If yes, please describe the radiation-related complications.

STEM CELL & BONE MARROW TRANSPLANT THERAPY

Did the applicant receive stem cell therapy or bone marrow transplant in the past? *

- Yes
- No

If yes, please write the date(s) and type(s) of past stem cell or bone marrow treatments.

Is the applicant currently undergoing any stem cell therapy or bone marrow transplants? *

- Yes
- No

If yes, please write the date(s) and type(s) of current stem cell or bone marrow treatments.

Is the applicant currently or have they ever been bothered by or experienced any complications related to stem cell therapy or bone marrow transplants? *

- Yes
- No

If yes, please describe the stem cell or bone marrow treatment-related complications.

Labs

Date of last blood lab evaluation *

(mm/dd/yyyy)

Most recent absolute neutrophil count >0.5? *

- Yes
- No

Most recent hemoglobin > 8.0? *

- Yes
- No

Most recent platelet count > 50? *

- Yes
- No

General Medical History

Please indicate the applicant's medical conditions below *

- [ ] No known medical issues other than cancer
- [ ] None of the issues listed below
- [ ] Respiratory problems (e.g. asthma)
- [ ] Cardiac problems
- [ ] Gastrointestinal problems
- [ ] Genitourinary problems
- [ ] Neurological problems (including seizures and migraines)
- [ ] Auditory or visual problems
- [ ] Joint problems
- [ ] Significant physical weakness of extremities or history of limb amputation
- [ ] History of hypertension
- [ ] History of diabetes
- [ ] History of bleeding/coaguation disorders, DVT or PE
- [ ] History of acute mountain sickness, high altitude pulmonary or cerebral edema

Please describe all known medical conditions indicated above as appropriate (e.g. currently controlled by medications, potential triggers or complications, frequency and date of most-recent episode). This is especially important for seizure and bleeding-related conditions.

Does the applicant have a history of smoking? *

- Yes
- No

If yes, please describe number of years and packs per day as well as, if applicable, quit date.

Does the applicant have a history of substance abuse? *

- Yes
- No

If yes, please describe (substance, duration, recovery date, etc.).

Does the applicant have any physical, cognitive, sensory, or emotional conditions that could interfere with his/her ability to participate in this program? *

- Yes
- No

If yes, please describe the condition and your concerns.

Allergies and Medications

Is the applicant allergic to medications, foods, insects, or something else of which we should be aware? *

- Yes
- No

If yes, please list allergies, describe reactions, and let us know whether an epi-pen is carried by the applicant.

Current prescription and non-prescription medications: dose, frequency, method of administration, and reason for use. *

Physical Exam

Height *

Weight *

Blood Pressure *

Heart Rate *

Oxygen Saturation *

Appearance *

- Normal
- Abnormal

Ears, Eyes, Nose & Throat *

- Normal
- Abnormal

Respiratory *

- Normal
- Abnormal

Cardiac *

- Normal
- Abnormal

Abdomen *

- Normal
- Abnormal

Lymphatic *

- Normal
- Abnormal

Genitourinary *

- Normal
- Abnormal

Musculoskeletal *

- Normal
- Abnormal

If abnormal for any of the above, please describe.

Pregnant *

- Yes
- No
- N/A

Date Medical Form Completed * (mm/dd/yyyy)

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