

RECEIPT OF APPROVED BOOKLETS ON BREAST CANCER TREATMENT

I _____ acknowledge that
(Name of Patient)

I have received a copy of either Breast Cancer Treatment Guidelines for Patients or
What You Need to Know About Breast Cancer given to me by my physician.

(Name of Physician)

Signature of Patient

Date of Receipt

Location where written summary is received
(e.g. physician's office, hospital, etc.)