Northwestern Medicine

Northwestern Medicine Gynecological Oncology

Woman to Woman Program

Application for Mentorship

Demographic information

Name _____

Address _____

Email address _____

Primary phone number ☐ cell ☐ home ☐ work _____

Days of week you are available: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Time of day you are available: ☐ Morning ☐ Afternoon ☐ Evening

Date of birth: Month_____ Day_____ Year_____

Current age _____

Age(s) at diagnosis _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership

Do you have children? ☐ Yes ☐ No

Ethnic origin: ☐ African American ☐ Asian American ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other

Primary language_____

Educational background _____

Occupation _____

Employment status during treatment: ☐ Full time ☐ Part time ☐ Retired ☐ Leave of absence/Disabled ☐ Unemployed

Current employment status: ☐ Full time ☐ Part time ☐ Retired ☐ Leave of absence/Disabled ☐ Unemployed

Special skills (e.g., sign language, etc.) _____

Hobbies/interests _____

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More about you

Please indicate which of the following are currently the most stressful for you:

- ☐ Career/job
- ☐ Emotional distress
- ☐ Fatigue
- ☐ Fear of death
- ☐ Fear of recurrence
- ☐ Fertility
- ☐ Finances
- ☐ Nutritional concerns
- ☐ Parenting
- ☐ Physical changes
- ☐ Relationships
- ☐ Sexuality
- ☐ Other:_____

Please indicate which of the following emotions you felt after your diagnosis:

- ☐ Anxiety
- ☐ Depression
- ☐ Fear/worry
- ☐ Stress
- ☐ Denial
- ☐ Hope
- ☐ Sadness
- ☐ Guilt
- ☐ Loneliness
- ☐ Other:_____

Please indicate which of the following you experience in a typical week, and how often:

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed or hopeless	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself, or feeling that you are a failure or that you have let yourself or your family down	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed, or the opposite—being fidgety or restless, moving around a lot more than usual	☐	☐	☐	☐
Thoughts that you would be better off dead or thoughts of hurting yourself	☐	☐	☐	☐

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If you are experiencing any of the above, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

_____

_____

Please indicate your support system:

☐ Spouse/significant other ☐ Children ☐ Parents ☐ Therapist

☐ Friends ☐ Siblings ☐ Faith

☐ Other:_____

Why are you interested in being paired with a mentor?

_____

_____

We always prioritize cancer type when pairing mentors with mentees. In the event a mentor with your cancer type is not available, are you comfortable being paired with someone who has a different gynecologic cancer? ☐ Yes ☐ No

Is there something unique to your cancer journey, an experience you would prefer your mentor to have had (hysterectomy, children after treatment), or something that you do (personally or professionally), that you would like us to take into consideration when pairing you with a mentor?

_____

_____

I hereby confirm that the information provided in the above application form is true and complete to the best of my knowledge. I understand that providing false information may disqualify me from consideration as a mentee. I will consider all information that I gain in my mentee position to be confidential. I understand that my mentee position will be terminated in an event of a breach of confidentiality.

Print name_____

Signature_____

Date:_____

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