

# Connections<sup>®</sup>

If you or a family member/friend has a brain tumor and would like to be put in touch with someone in a similar situation, we will try to make a connection. If you would like to participate in CONNECTIONS<sup>®</sup>, please complete the form below and return it to us.

Return to:

**American Brain Tumor Association**  
2720 River Road, Des Plaines, IL 60018

This form will be sent to your potential CONNECTIONS<sup>®</sup> match. Please Print.

Name		Age
Address		
City	State	Zip
Phone (optional)	E-mail	

I would like to participate in CONNECTIONS<sup>®</sup> and give the American Brain Tumor Association permission to copy this information and forward it to my prospective match.

Signature *(must be signed by parent or legal guardian if participant is under the age of 18)* Date

## I AM:

- A brain tumor patient/survivor
- The spouse/significant other of a brain tumor patient
- A parent of a survivor 18 or younger - Age: \_\_\_\_\_
- A parent of an adult survivor
- Other (please specify): \_\_\_\_\_

## TUMOR TYPE:

\_\_\_\_\_

## TREATMENT: *(check all that apply)*

- Surgery
- Radiation
- Chemotherapy
- Stereotactic Radiosurgery

## MY SPECIAL INTERESTS ARE:

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