

## Therapy Recommendation Form (only for physicians)

Infoline for medical professionals  
E-mail: [infoline@iscador.com](mailto:infoline@iscador.com)  
[www.iscador.com](http://www.iscador.com)

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79539 Lörrach

Kindly provide all required information in print or type in order to receive an ISCADOR therapy recommendation for your patient.

### Sender:

Title, first name, last name: \_\_\_\_\_

Stamp

Street: \_\_\_\_\_

Postcode, city: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

I authorise Isccador AG, Spitalstr. 22, 79539 Lörrach, Germany, to advise me medically with a free, non-binding, individual treatment recommendation based on the information I have provided. My personal data will be stored for the purpose of contacting me and providing me with information about Isccador AG and its products. It will only be used for these purposes and will not be passed on to unauthorised third parties. The data may be transferred to the headquarters of Isccador AG in Switzerland, a third country with an adequate level of data protection according to the EU Commission. I have the right to request full disclosure of my personal data via [info@iscador.com](mailto:info@iscador.com).

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Patient data: Initials: \_\_\_\_\_ ☐ Female ☐ Male Date of birth: \_\_\_\_\_  
First name Last name Day Month Year

Tumour diagnosis: \_\_\_\_\_

First diagnosis: \_\_\_\_\_ Relapse: ☐ no ☐ yes, since: \_\_\_\_\_  
Month Year

Metastases: ☐ no ☐ yes, which \_\_\_\_\_

For breast cancer: ☐ premenopausal ☐ perimenopausal ☐ postmenopausal (also drug-induced)

<b>Therapies:</b>	Surgery	<input type="checkbox"/> no	<input type="checkbox"/> yes, when? _____	<input type="checkbox"/> planned	<b>General condition:</b>
	Chemotherapy	<input type="checkbox"/> no,	if yes: <input type="checkbox"/> completed <input type="checkbox"/> ongoing	<input type="checkbox"/> planned	
	Radiotherapy	<input type="checkbox"/> no,	if yes: <input type="checkbox"/> completed <input type="checkbox"/> ongoing	<input type="checkbox"/> planned	
	Hormonal therapy	<input type="checkbox"/> no,	if yes: <input type="checkbox"/> completed <input type="checkbox"/> ongoing	<input type="checkbox"/> planned	
	Immunotherapy	<input type="checkbox"/> no,	if yes: <input type="checkbox"/> completed <input type="checkbox"/> ongoing	<input type="checkbox"/> planned	
					<input type="checkbox"/> good
					<input type="checkbox"/> reduced

**Additional:** Known allergy to mistletoe ☐ no ☐ yes, host tree: \_\_\_\_\_  
Acute inflammatory or high-fever diseases ☐ no ☐ yes, namely: \_\_\_\_\_  
Chronic granulomatous diseases ☐ no ☐ yes, namely: \_\_\_\_\_  
Florid autoimmune diseases ☐ no ☐ yes, namely: \_\_\_\_\_  
Hyperthyroidism with tachycardia ☐ no ☐ yes, namely: \_\_\_\_\_

Further questions/information: \_\_\_\_\_