PATIENT REFERRAL FORM

American Cancer Society

Notice to Patient

The American Cancer Society (ACS) offers services and information that could help you while you are dealing with your cancer. The information that you share on this form will be shared with the ACS so that they can contact you about the cancer information, services and resources that you request.

The ACS cares about your privacy and will protect and use your information only in accordance with its Privacy Policy, available at www.cancer.org. The ACS will use the information contained on this form to contact you about the services you have requested.

With your permission given below, the ACS may also use your information to contact you about other programs and services that may be of interest to you, to invite you to events in your community, and/or to tell you about volunteer or other support opportunities. If you would like to give the Society permission to contact you regarding these other opportunities, please initial here: _____ **(Patient Initials)**

If you have questions about your cancer, the ACS, its programs, services or privacy standards, or to change your contact preferences, please visit **www.cancer.org** or call **1-800-227-2345. The ACS is available 24 hours a day, 7 days a week.**

Provider Information

Healthcare Provider Name: Hematology & Oncology Associates of Northeastern | ACS ID: 1-15EXBA6

Referral Contact Name: | Phone: ( ) –

Patient Information *(Minimum of one method of contact required). Information shared here will assist us in efficiently coordinating services.*

Patient Name: (required)

Primary Address: ☐ Home ☐ Business ☐ Other

City: *State:* *Zip Code:*

Primary Phone: ( ) – ☐ Home ☐ Cell ☐ Business

Alternate Phone: ( ) – ☐ Home ☐ Cell ☐ Business

Email: ☐ Personal ☐ Business

Date of Birth: *ex: MM/DD/YYYY* | Primary Language: ☐ English ☐ Spanish ☐ Other: *Please List*

Race: ☐ African American/Black ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic/Latino ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Two or more races ☐ Declined to Share ☐ Other: *Please List*

Gender: ☐ Female ☐ Male

Diagnosis

Date of Diagnosis: *ex: MM/DD/YYYY* | Type of Cancer: | ☐ Recurrence

Insurance: ☐ Medicaid ☐ Medicare ☐ Medicare + Medicaid ☐ Medicare + Private ☐ Military ☐ Private ☐ Uninsured ☐ Declined to Share

☐ Personal Health Manager Requested (Kit to organize your cancer and treatment information) ☐ English ☐ Spanish ☐ Other Language: *Please List*

Requested Services

Best Time to Call: *ex: 00:00* ☐ AM ☐ PM | OK to leave a message: ☐ Y ☐ N

☐ Transportation to cancer treatment | First Date Needed: *ex: MM/DD/YYYY* | Time: *ex: 00:00* ☐ AM ☐ PM

☐ Lodging during cancer treatment | First Date Needed: *ex: MM/DD/YYYY*

☐ One-on-one breast cancer support (Reach to Recovery) | Treatment Type: ☐ Early Support ☐ Lumpectomy ☐ Mastectomy ☐ Chemotherapy ☐ Radiation ☐ Advanced

☐ Classes to enhance appearance & self-esteem during treatment (Look Good Feel Better) | Skin Tone: ☐ Dark ☐ Extra Dark ☐ Light ☐ Medium

☐ Resources/Referrals for other needs: | ☐ Wig or head-coverings

Comments/Other information you would like us to know:

Healthcare Provider Instructions: The Notice above regarding American Cancer Society's use of information must be shared with the patient prior to submitting this form to the American Cancer Society. ACS will rely on Health Care Provider's submission of any Patient Referral Form as evidence that this Notice has been communicated to patient. Once completed, please fax form to **877-428-2862** or Email form to **SSBCREF@CANCER.ORG**

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