CANCER FOUNDATION LEAGUE REFERRAL INFORMATION

411 Calypso Street
Monroe, LA 71201
318-966-1953 or 1-800-393-2029
Fax: (318) 966-1952

(PRINT OR TYPE LEGIBLY)

REFERRAL SOURCE:
Name:_____ **Date of Referral:**_____
Phone:_____ **Relationship:**_____
Agency Affiliation:_____

PATIENT INFORMATION:
Name:_____ **SS#:**_____
Address:_____ **Date of Birth:**_____
City:_____ **State:**_____ **Zip:**_____ **Parish:**_____
Daytime Phone:_____ **Alternate Daytime Phone:**_____
Diagnosis: CANCER OF _____
Date diagnosed:_____
Is patient aware of diagnosis? _____ **Family?** _____

***MUST PROVIDE PATHOLOGY REPORT FOR VERIFICATION OF DIAGNOSIS OF CANCER.**

Receiving medical care at:
1)_____ **Physician's Name:**_____
Type of treatment at this time:_____
2)_____ **Physician's Name:**_____
Type of treatment at this time:_____

HOUSEHOLD INFORMATION: List ALL persons who are LIVING WITH THE PATIENT.

Name	Age	Relationship to Patient

INCOME: List ALL SOURCES of TOTAL household income AND include AMOUNTS OF EACH SOURCE OF INCOME. **(Includes employment, SS, SS Disability, SSI, Food Stamps, other)**

1._____ **4.**_____
2._____ **5.**_____
3._____ **6.**_____

Total Household Income:_____**(MUST ATTACH PROOF OF INCOME)**
(example – check stub, W2, bank statement, Social Security letter)

Medicare #:_____
Medicaid #:_____
Private Insurance: Yes_____ No_____ Prescription Coverage: Yes_____ No_____
Supplemental or Cancer Policy: _____
Veterans:_____ **Hospice:**_____

Monthly rent: $_____ **(or) Monthly mortgage: $**_____

Are you receiving help from any other organization at this time? Yes_____ No_____
Name:_____ **Type of help:**_____ **$ amount:**_____

Have you ever received assistance from CFL before? _____ When?_____

STATISTICAL INFORMATION: (TO BE USED FOR STATISTICAL REPORTS ONLY)

RACE_____ SEX_____ NATIONALITY_____

This request is for help with: *(Check appropriate one)*

____ Prescription medications
____ Medical supplies
____ Transportation to/from Treatment
____ Nutritional Supplements
____ Other services (Explain) _____
_____

CFL DOES NOT PAY MEDICAL BILLS (DOCTOR, HOSPITAL, ETC.). CFL DOES NOT PAY PHONE, CABLE BILLS OR UTILITY DEPOSITS.

The patient agrees to defend, indemnify, and hold harmless the Cancer Foundation League and its officers, directors, members, and all volunteers from and against any claims, demands, causes of action, damages, or liabilities, or any cause whatsoever, including reasonable attorney's fees. This referral may be amended at any time and is limited to funds available for distribution.

_____
Patient's Signature

_____
Date

The Cancer Foundation League and the Louisiana Cancer Foundation ARE NOT affiliated with the American Cancer Society. We provide assistance to any cancer patient who lives in or is receiving treatment in Northeast Louisiana.

Please note: The application will not be considered unless all sections are filled out and requested documentation is provided.