

PATIENT REFERRAL FORM



Notice to Patient

The American Cancer Society (ACS) offers services and information that could help you while you are dealing with your cancer. Please sign below if you agree that your doctor (or Health Care Provider) may share your information with the ACS. They will then contact you about the cancer information, services and resources that you request.

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

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](http://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](http://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: Emerald Coast Cancer Center - Fort Walton Beach	ACS ID: 1-1BU1KN5
	Referral Contact Name:	Phone: (850) 863 - 3148
Patient Information (Minimum of one method of contact required). Information shared here will assist us in efficiently coordinating services.	Patient Name: (required)	
	Primary Address:	<input type="checkbox"/> Home <input type="checkbox"/> Business <input type="checkbox"/> Other
	City:	State: Zip Code:
	Primary Phone: ( ) -	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Business
	Alternate Phone: ( ) -	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Business
	Email:	<input type="checkbox"/> Personal <input type="checkbox"/> Business
	Date of Birth: <small>ex: MM/DD/YYYY</small>	Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: <small>Please List</small>
Race: <input type="checkbox"/> African American/Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Two or more races <input type="checkbox"/> Declined to Share <input type="checkbox"/> Other: <small>Please List</small>		
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male		
Diagnosis	Date of Diagnosis: <small>ex: MM/DD/YYYY</small>	Type of Cancer: <input type="checkbox"/> Recurrence
	Insurance: <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Medicare + Medicaid <input type="checkbox"/> Medicare + Private <input type="checkbox"/> Military <input type="checkbox"/> Private <input type="checkbox"/> Uninsured <input type="checkbox"/> Declined to Share	
<input checked="" type="checkbox"/> Personal Health Manager Requested (Kit to organize your cancer and treatment information) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other Language: <small>Please List</small>		
Requested Services	Best Time to Call: <small>ex: 00:00</small>	<input type="checkbox"/> AM <input type="checkbox"/> PM OK to leave a message: <input type="checkbox"/> Y <input type="checkbox"/> N
	<input type="checkbox"/> Transportation to cancer treatment	First Date Needed: <small>ex: MM/DD/YYYY</small> Time: <input type="checkbox"/> AM <input type="checkbox"/> PM <small>ex: 00:00</small>
	<input type="checkbox"/> Lodging during cancer treatment	First Date Needed: <small>ex: MM/DD/YYYY</small>
	<input type="checkbox"/> One-on-one breast cancer support (Reach to Recovery)	Treatment Type: <input type="checkbox"/> Early Support <input type="checkbox"/> Lumpectomy <input type="checkbox"/> Mastectomy <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Advanced
	<input type="checkbox"/> Classes to enhance appearance & self-esteem during treatment (Look Good Feel Better)	Skin Tone: <input type="checkbox"/> Dark <input type="checkbox"/> Extra Dark <input type="checkbox"/> Light <input type="checkbox"/> Medium
	<input type="checkbox"/> Resources/Referrals for other needs:	
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 <a href="mailto:SSBCREF@CANCER.ORG">SSBCREF@CANCER.ORG</a>		