



Patient Referral

CONFIDENTIAL INFORMATION

Counselor Name _____
Phone _____ Email _____
Case # _____ Date _____

Patient Name _____ (First/Initial/Last)

Patient Address _____
Street City Zip

Home Phone _____ Work Phone _____

Mobile Phone _____ Email _____

Date of Birth _____ Social Security Number _____

Male Female Number in Household _____

Primary Physician _____ Contact Phone # _____

Oncologist _____ Contact Phone # _____

Cardiologist _____ Contact Phone # _____

Diagnosis _____

Have you sought Disability ? Yes No Status? _____

Have you sought Medicaid ? Yes No Status? _____

Have you sought Assistance from American Cancer Society ? Yes No
Status? _____

Have you sought Assistance from another agency ? Yes No
Status? _____

Patient Must Sign and Provide Documentation for Referral

Cancer Care Foundation of Tidewater (CCFOT) is a nonprofit organization chartered by the Commonwealth of Virginia. We will act on your behalf for aid, education, counsel and assistance.

I, _____ (print name), according to the *Privacy Acts* legislated for the confidentiality and privacy of my health information, do hereby permit release of my information to this foundation and cognate agencies that may be contacted in discussing my **non-medical** needs. Please **sign** and **date** below signifying your permission to release information to CCFOT.

Signature _____ Date _____

Please attach Letterhead Documentation of Medical Supervision to Referral.

Requested Area of Assistance

- Household Expenses
- Prescription Assistance
- Fuel
- Food

Please list up to 3 bills and dollar amount requested:

For consideration of payment, copies of invoices must be attached to Referral.

CCFOT provides information, guidance, and support to patients throughout Tidewater. Please indicate other areas of interest.

- Information
- Volunteer Opportunities
- CCFOT Newsletter
- Support Group
- Emotional Support
- Other

Please provide any other comments/information: