

Cancer Association of Anderson

215 E. Calhoun Street

Anderson, SC 29621

Phone: 864-222-3500 Fax: 864-222-3502

APPLICATION FOR SERVICE

Date _____ Soc. Sec. # _____ Phone _____

Patient's Name _____ E-mail _____

Address _____ City _____ Zip _____ County _____

Birth date _____ Age _____ Sex _____ Race _____ Marital Status _____ # in Family _____

Caregiver's Name _____ Relationship _____

Address _____ Phone _____

OTHER PEOPLE WHO MAY CONTACT CAA ON BEHALF OF PATIENT: _____

Referred by _____ Patient's cancer doctor _____

Type of cancer _____ Current treatment _____

Date of diagnosis or most recent reoccurrence _____

Insurance Coverage: Medicare _____ Medicaid _____ Indigent _____ Other _____

Private insurance (name of company or plan) _____

Other _____

Type of service(s) needed: 1) _____

2) _____

3) _____

Source of support (Patient) _____

Source of support (Spouse) _____

STAFF USE ONLY

This patient was informed of the following services:

____ Financial Aid ____ Oncology Rehab ____ Hat and Wig Closet ____ Support Groups

This patient was given a: Prayer shawl ____ Yes ____ No Lydia Bag # _____

*Faxed to Free Clinic: _____
Date

"Doctor's Form": _____
Date

Cancer Association of Anderson Release Statement

I understand that by signing this statement, I give Cancer Association of Anderson permission to assist me with community referrals and/or networking with other cancer patients, and if necessary, the pursuit of insurance related matters through designated carriers. This consent also includes any release or exchange of information needed by Cancer Association of Anderson staff members or volunteers for requested assistance on my behalf. I understand that this consent may be revoked by me or my representative at any time.

Cancer Association of Anderson may send correspondence to the address and e-mail address indicated on this application:
 Yes _____ No _____

Client Signature: _____ **Date:** _____

If client is unable to sign, client's personal representative must sign below.

Representative Signature: _____ **Date:** _____

Cancer Association of Anderson MEDICATION FORM

Name:	Address:
Phone Number:	Birth Date:

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, ginkgo). Include medications taken as needed (example: nitroglycerin).

DATE Started	NAME OF MEDICATION / DOSE	Prescribing Doctor		Notes: Reason for taking

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Email: kristie@caanderson.org

DOCTOR'S FORM

_____ is receiving services provided by the Cancer Association of Anderson.

THE PATIENT/GUARDIAN, BY SIGNING BELOW, HEREBY GIVES PERMISSION TO HER/HER PHYSICIAN TO RELEASE THE HEALTH INFORMATION LISTED BELOW:

Date of Birth

Patient or Guardian's Signature

Address

City, State Zip

Date

Phone

THE PHYSICIAN SHOULD COMPLETE THE FOLLOWING AND MAIL OR FAX TO THE ABOVE ADDRESS or GIVE IT TO THE PATIENT TO RETURN TO CAA

Patient _____

Diagnosis _____

This patient has cancer. YES NO

Is this patient in ACTIVE treatment for cancer? YES NO

CANCER RELATED DRUGS ONLY _____

Comments _____

Physician's Signature

Address

Supporting Staff (contact nurse or office assistant): _____

Date

Phone