Cancer Association of Anderson
215 E. Calhoun Street
Anderson, SC 29621
Phone: 864-222-3500 Fax: 864-222-3502
Email: kristie@caanderson.org

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)_____

This information assists us with potential donors and grants. We do not share personal information with any other organization, etc.

Employer or Source of Support (Patient) _____
Employer or Source of Support (Spouse) _____
Church Affiliation: _____
Veteran: Yes ☐ No ☐

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: _____** **"Doctor's Form": _____**
Date **Date**

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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, gingko). Include medications taken as needed (example: nitroglycerin).

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

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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**