



American Cancer Society Hope Lodge

208 Charlotte Avenue Nashville, TN 37203
(615) 342-0840 (Phone) (615) 342-0888 (Fax)

Hope Lodge Request Form: Complete ALL Fields

First time Guest:
Returning Guest:

PATIENT INFORMATION

Reservation Start Date: _____
Reservation End Date: _____

Personal

DOB: _____ Gender: _____
Name: _____ Daytime Phone: _____
Home Address: _____ Evening Phone: _____
City/ST/Zip: _____ Cell Phone: _____
Ethnicity: _____ Type of Insurance: _____
Primary/Secondary Languages: _____ Email: _____

Medical Information

Date of Diagnosis: _____
Diagnosis/Cancer Site: _____ Frequency (treatments/per week): _____
Treatment Facility: _____ Type of Treatment: _____
Treatment Start Date: _____ End Date: _____
Current Phase: _____ Current Phase: _____
Is the patient enrolled in a clinical trial? Yes No Type/Length _____ Is this a transplant patient? Yes No
Social Worker/Coordinator: _____ Phone: _____
Email: _____ Pager: _____
Treating Physician: _____ Phone/Pager #: _____

I explained the American Cancer Society (ACS) Hope Lodge services to the patient, and I have obtained express authorization to disclose this information to the ACS for purposes of applicable follow up and referral to Hope Lodge. _____ (please

Other

Is the patient bringing a caregiver? Yes No
If no, physician must supply letter stating patient is ambulatory (able to evacuate building in case emergency) and able to care for him/herself
Does the patient need a wheelchair accessible room? Yes No
Does the patient have any infectious diseases? Yes No
Does the patient understand English? ___Yes ___No Does the caregiver understand English? ___Yes ___No
How did you hear about Hope Lodge?
Other relevant special needs? _____
Has the patient or caregiver ever been convicted of a crime of violence, crime of domestic violence, crime against a child, crime of theft, or a crime involving illegal drugs? ___Yes ___No
Is the patient or caregiver: Currently on probation or parole? ___Yes ___No Have a civil protection order against them? ___Yes ___No
Required to register on the state or national sex offender registry?

CAREGIVER INFORMATION

Name: _____ Relationship to Patient: _____
Address: _____ DOB: _____
City/Zip: _____ Email: _____
Phone: _____ Cell Phone: _____
Please give **Emergency Contact** information if other than listed above: _____
(Name) (Relationship) (Phone)

TREATING PHYSICIAN OR SOCIAL WORKER'S STATEMENT

As the referring source, I affirm that to the best of my knowledge, the patient listed above does not have any infectious disease symptoms. I have reviewed the eligibility requirements with the patient, and I affirm that he/she meets all of these. If an i

Treating physician or healthcare staff person's name (please print)

Signature

Office Use Only

Rec'd by: _____ Date: _____

ACS cares about privacy and protects how we use your patients' information. Visit www.cancer.org to view our privacy policy.