

# American Cancer Society Hope Lodge Referral Form

Phone: 216.844.4673

Fax: 216.844.2959

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Month Day Year

Home Address: \_\_\_\_\_  
Street City State Zip

Ohio County: \_\_\_\_\_ Country: \_\_\_\_\_

Home Phone Number: ( ) \_\_\_\_\_ - \_\_\_\_\_

## Patient is

Independent in self-care or needs minor assistance from caregiver

## Special Needs

Requires ADA Room  Requires TTY Room  Requires Service Animal

Uses Adaptive Equipment

Wheelchair  Walker  Cane  TTY

Other: (Please specify) \_\_\_\_\_

Patient Employed By: \_\_\_\_\_

Active

Retired

Diagnosis: \_\_\_\_\_

Treatment:  Chemotherapy  Radiation  Surgery  BMT  
Type of BMT: \_\_\_\_\_

Other (please specify) \_\_\_\_\_

Referral By: \_\_\_\_\_ Title: \_\_\_\_\_ Phone #: \_\_\_\_\_

Cleveland Hospital: \_\_\_\_\_ Cleveland Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_  
Name of caregiver staying with patient Relationship to patient

Caregiver meets criteria for caregiver at Hope Lodge

Caregiver is able to fulfill role of caregiver at Hope Lodge

Check-In Date\* \_\_\_\_\_ Check-Out Date\* \_\_\_\_\_

Note: It is the responsibility of the referring professional to notify the Hope Lodge director in advance if the check-out date changes.

*Healthcare Provider Certification: I acknowledge that I have reviewed the guidelines and rules of the Hope Lodge and certify that to the best of my knowledge, this patient and caregiver meet those requirements.*

Signature of referring professional: \_\_\_\_\_ Date: \_\_\_\_\_