American Cancer Society Hope Lodge

Office Address: 4550 E Bell Rd, Ste 126, Phoenix, AZ 85032
Phone: 1-866-500-3272 Fax: (602) 404-1118

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: DROP DOWN ______________ 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, who agreed with the disclosure of this information to the ACS for purposes of applicable follow up and referral to Hope Lodge.* _________________ *(please initial)

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/caregiver have any communicable disease? ☐ Yes ☐ No
If yes, please specify. Have they been determined by a physician to be noninfectious? Physician will need to supply letter of explanation.
____

Does the patient need a wheelchair accessible room? ☐ Yes ☐ No

How did you hear about Hope Lodge? ______________________________

*Other relevant special needs?*______________________________

Has the patient or caregiver ever been convicted of a crime? ☐Yes ☐No *If yes, type of crime?* ______________ *When convicted?* ______________

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 issue arises with this guest during his/her stay, I will cooperate with the Hope Lodge staff in correcting the problem and/or assist the Hope Lodge staff in finding alternate housing for the guest.

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

Office Use Only
Rec'd by: Date:

____
Date

Rev. 3/11/09