



First time Guest: <input type="checkbox"/> Returning Guest: <input type="checkbox"/>	PATIENT INFORMATION	Reservation Start Date: _____ Reservation End Date: _____
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<u>Personal</u>		DOB: _____	Gender: _____
Name: _____	Daytime Phone: _____		
Home Address: _____	Evening Phone: _____		
City/ST/Zip: _____	Cell Phone: _____		
Ethnicity: _____	Type of Insurance: _____		
Primary/Secondary Languages: _____	Email: _____		

<u>Medical Information</u>		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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Type/Length _____
Is this a transplant patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Social Worker/Coordinator: _____	Phone: _____	
Email: _____	Pager: _____	
Treating Physician: _____	Phone/Pager #: _____	
<i>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)</i>		

<u>Other</u>	
Is the patient bringing a caregiver? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, physician must supply letter stating patient is ambulatory (able to evacuate building in case emergency) and able to care for him/herself</i>	Does the patient/caregiver have any communicable disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please specify. Have they been determined by a physician to be noninfectious? Physician will need to supply letter of explanation.</i>
Does the patient need a wheelchair accessible room? <input type="checkbox"/> Yes <input type="checkbox"/> No	How did you hear about Hope Lodge? _____
Other relevant special needs? _____	
Has the patient or caregiver ever been convicted of a crime? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____ <div style="display: flex; justify-content: space-between; width: 100%;"> (Name) (Relationship) (Phone) </div>		

TREATING PHYSICIAN OR SOCIAL WORKER'S STATEMENT				
<i>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.</i>				
Treating physician or healthcare staff person's name (please print) _____	Signature _____			
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;">Office Use Only</td> </tr> <tr> <td style="padding: 2px;">Rec'd by: _____</td> </tr> <tr> <td style="padding: 2px;">Date: _____</td> </tr> </table>	Office Use Only	Rec'd by: _____	Date: _____	Date _____
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Rev. 3/11/09				