



# American Cancer Society Memorial Foundation Hope Lodge

2008 Charlotte Avenue Nashville, TN 37203  
(615) 342-0840 (Phone) (615) 342-0888 (Fax)

## Hope Lodge Referral Form

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  
Will this patient require refrigeration for medications?  Yes  No

Social Worker/Coordinator: \_\_\_\_\_  
Email: \_\_\_\_\_ Phone: \_\_\_\_\_

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 need a wheelchair accessible room?  Yes  No

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.*

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 (Caregivers must be over 18 years of age. No more than 2 caregivers permitted.)

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:

Rev. 3/11/09

Date