American Cancer Society Patrick F. Taylor Hope Lodge
2609 River Road New Orleans, LA 70121
(504) 219-2200 (Phone) (504) 219-2240 (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/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 (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: