



Hope Lodge Referral Form

Reservation Start Date: _____
 Reservation End Date: _____

PATIENT INFORMATION

First time Guest:
 Returning Guest:

Personal

DOB: _____ / _____ / _____ Gender: Male Female
 Name: _____ Home Phone: _____
 Home Address: _____ Cell Phone: _____
 City/ST/Zip: _____ Type of Insurance: Private Medicaid Uninsured
 Ethnicity: _____ Medicare VA/Military
 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: _____
 Is the patient enrolled in a clinical trial? Yes No Type/Length _____
 Is this a transplant patient? Yes No
 Social Worker/Coordinator: _____ Will this patient require refrigeration for medications? Yes No
 (Individual making referral) _____
 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.
 Wheelchair accessible room? Yes No
 Other relevant special needs? _____
 Has the patient or caregiver ever been convicted of a crime? Yes No If yes, type of crime? _____ When convicted? _____

PRIMARY CAREGIVER INFORMATION (Caregivers must be 18 years of age or older. 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: _____