



Phone

Fax

HOPE LODGE REQUEST FORM: Complete **ALL** Fields

The information on this form is kept in strict confidence and only used to ensure the safety and comfort of your stay at a Hope Lodge facility.

PATIENT INFORMATION:

First-time guest: Returning guest:

Requested lodging start date: _____ End date: _____

Name: _____ DOB: _____ Gender: _____

Home address: _____ Home phone: _____

Cell phone: _____

City/State/ZIP: _____

Email address: _____

Caregiver's name: _____ Relationship to patient: _____

Optional patient information (for recording purposes only)

Insurance type: _____ Ethnicity: _____

MEDICAL INFORMATION:

Date of diagnosis: _____

Diagnosis/Cancer site: _____

Type of cancer treatment: Chemo Radiation BMT Other (please explain): _____

Frequency (treatments per week): Daily Other (please explain): _____

Treatment start date (current phase): _____ End date (current phase): _____

Is the patient enrolled in a clinical trial? Yes No

Treatment facility: _____

Referring professional: _____ Title: _____

Phone: _____ Fax: _____

Email address: _____

Treating physician: _____

Phone: _____

OTHER:

Does the patient have any infectious diseases or infectious-disease symptoms? Yes No

Does the caregiver have any infectious diseases or infectious-disease symptoms? Yes No

Does the patient understand English? Yes No

Does the caregiver understand English? Yes No

Does the patient or caregiver need a wheelchair-accessible room? Yes No

Other relevant special needs? _____

Does the patient or caregiver have a service animal? Yes No

Has the patient ever been convicted of a crime of violence, a crime of domestic violence, a crime against a child, a crime of theft, or a crime involving illegal drugs? Yes No

Has the caregiver ever been convicted of a crime of violence, a crime of domestic violence, a crime against a child, a crime of theft, or a crime involving illegal drugs? Yes No

Is the patient currently on probation or parole? Yes No

Is the caregiver currently on probation or parole? Yes No

Does the patient have a civil protection order against himself/herself? Yes No

Does the caregiver have a civil protection order against himself/herself? Yes No

Is the patient required to register on a state or the National Sex Offender Registry? Yes No

Is the caregiver required to register on a state or the National Sex Offender Registry? Yes No

REFERRING PROFESSIONAL'S STATEMENT

As the referring source, I have reviewed the American Cancer Society's eligibility requirements with the patient and accurately documented his/her responses to the questions contained in this form. I have also explained the American Cancer Society guidelines and affirm that, to the best of my knowledge, the patient listed above does not have any infectious diseases or infectious-disease symptoms. Finally, I have explained the American Cancer Society Hope Lodge services to the patient, and I have obtained express authorization to disclose this information to the American Cancer Society for purposes of applicable follow-up and referral to the Hope Lodge facility.

Treating physician or referring professional's name (please print)

Signature

Date

The American Cancer Society cares about your privacy and protects how we use your information.
To view our full privacy policy or if you have any questions, please call us at 1-800-227-2345
or visit us online at cancer.org and click on the "privacy" link at the bottom of the page.