CANCER SERVICES

550 Lobdell Avenue | Baton Rouge, LA 70806 | cancerservices.org |225-927-2273

Fax to Cancer Services
(225) 927-1468

Referral Information

(TO BE COMPLETED BY A REFERRING HEALTHCARE PROVIDER)			
Last Name: First Name: Middle:		Address:	
Patient Contact Phone Number:	Patient Parish of Residence:	Patient Date of Birth:	Gender:

Referring Healthcare Provider (social worker, nurse, physician):	Date of Referral:	Healthcare Provider Contact Phone Number:
Type of Cancer/Location:	Treatment Facility:	Treating Physician:

This patient may benefit from (check any/all that apply):

ALL CLIENTS
- ☐ Medical Supplies/Equipment
- ☐ Emotional Support
- ☐ Educational Information and Programs
- ☐ Healthcare Navigation
- ☐ Children's Programs

FINANCIALLY ELIGIBLE CLIENTS
- ☐ Financial Assistance - less than 250% of FPL

Nutritional Supplement: **This section must be completed by a physician, physician assistant, nurse, nurse practitioner or dietician.** By completing this section, you are confirming that your patient needs nutritional supplement. (specify which product, calories listed are per 8 oz. serving)

☐ Boost (240 cal) ☐ Boost Plus (360 cal) ☐ Resource 2.0 (480 cal) ☐ Boost Glucose- diabetic (250 cal)

Healthcare Provider Printed Name:	Healthcare Provider Signature:

I hereby give permission to my healthcare provider to release my cancer diagnosis to Cancer Services. I also give Cancer Services permission to contact the phone number referenced above in order to discuss the services available.

Patient's signature: Date:

Comments: