



550 Lobbell Ave., Baton Rouge, LA 70806  
 Phone: (225) 927-1329, 1-800-883-4515, Fax: (225) 927-1468

### Application for Services

Confirmation of a cancer diagnosis from a healthcare provider is required.

PATIENT INFORMATION					
Last Name:		First Name:		Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.
Marital Status (circle one) Single / Married / Divorced / Separated / Widowed					
Social Security #:		Sex M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth:		Age:
Spouse/Partner's Name:					
Street Address:			Mailing Address (if different from street address):		Parish:
City:		State:	ZIP Code:		Home Phone:
Cell Phone:		Work Phone:		E-mail Address:	
Ethnicity: <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other:					
Number of people in household:			Source of Income (social security, pension, employment, etc.):		
MEDICAL INFORMATION					
Type of Cancer:		Date of Diagnosis:   /   /		Date of Surgery:   /   /	
Are you currently receiving chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No			Are you currently receiving radiation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Oncologist:		Radiologist:		Other Attending Physician:	
Medicines you are taking due to cancer:					
Medicines you are taking for other health reasons:					
Are you being treated for diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No		Medical Insurances (s):		Prescription Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
CSGBR PROGRAM INFORMATION					
Are you interested in receiving our monthly newsletter about support groups and speakers? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you interested in a volunteer visiting you at home? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you interested in our counseling program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you interested in speaking to a cancer survivor from our Peer-to-Peer program? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Are you interested in receiving information from the library about your type of cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, what specifically would you like to know?					
How would you like to receive that information? <input type="checkbox"/> Mail <input type="checkbox"/> At Cancer Services <input type="checkbox"/> E-mail (please supply email address at top of form)					

### KIDS KARE PROGRAM

The **Kids Kare** program is for children ages 4-21, who have a parent or legal guardian diagnosed with cancer.

Are you interested in your children taking part in our Kids Kare Program?  Yes  No

Name (s) and date(s) of birth of your children if interested in Kids Kare Program:

Name: _____	DOB: _____	Name: _____	DOB: _____
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Name: _____	DOB: _____	Name: _____	DOB: _____
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I give permission for my children to be registered in the Kids Kare program.

My children have permission to appear in photographs and on television for publicity purposes.  Yes  No

Signed by parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

### IN CASE OF EMERGENCY:

Name of local friend or relative:	Relationship to Patient:	Home Phone:	Cell Phone:
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Address:	City:	Zip:
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Name of Closest Relative (not living at same address):	Relationship to Patient:	Home Phone:	Cell Phone:
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Address:	City:	Zip:
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### RELEASE STATEMENT:

**I understand that by signing this statement, I give Cancer Services permission to assist the above-referenced client with community referrals and/or networking with other cancer patients, and if necessary, the pursuit of insurance related matters through designated carriers. This consent also includes any release or exchange of information needed by Cancer Services staff members for requested assistance on my behalf. I understand that this consent may be revoked by my representative or me at any time.**

Cancer Services may send correspondence to the address and e-mail address indicated on this application: Yes  No

When calling the contact numbers listed on this application, Cancer Services staff may:  
(check all that apply)

- leave messages on home answering machine
- leave messages on cell phone voice mail
- leave messages on work voice mail
- not leave voice messages
- speak with anyone who answers the phone(s)
- speak with the following individuals: (please list individual names)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If client is unable to sign, client's personal representative must sign below.**

**Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to Client:** \_\_\_\_\_

**Reason that client is unable to sign:** \_\_\_\_\_