CANCER SERVICES

550 Lobdell Avenue | Baton Rouge, LA 70806
O: 225-927-2273 | F: 225-928-8448 | cancerservices.org

Application for Services

Last Name:	First Name:	Middle Initial:

Type of Cancer:	Date of Birth:	Sex: M❑ F❑ T❑

Street Address:	Mailing Address (if different from street address):

City:	State:	ZIP Code:	Parrish:

Main Phone: ❑ Home ❑ Cell ❑ Work	Second Phone: ❑ Home ❑ Cell ❑ Work	E-mail Address:

Please select the category that best describes your current income (for statistical purposes only):

❑ Less than $20,000 ❑ $20,000 to $34,999 ❑ $35,000 to $49,999
❑ $50,000 to $74,999 ❑ $75,000 to $99,999 ❑ $100,000 or more

Marital Status: ❑Single ❑ Married ❑ Partnered ❑ Separated ❑ Divorced ❑Widowed

Ethnicity: ❑African American ❑Asian ❑Caucasian ❑Hispanic ❑Other:

Emergency Contact Information

Name:	Relationship to Patient:

Main Phone: ❑ Home ❑ Cell ❑ Work	Second Phone: ❑ Home ❑ Cell ❑ Work	E-mail Address:

Address:	City:	State:	Zip:

Needs Assessment

I am interested in the following:

❑ Nutritional Supplement (Boost, Glucose, etc.) ❑ Financial Assistance ❑ Support Groups
❑ Wigs, Scarves or Hats/Bras or Prostheses ❑ Exercise Programs ❑ Peer Support
❑ Medical Equipment ❑ Children's Programs ❑ Counseling
❑ Medical Supplies ❑ Information regarding your diagnosis or treatment

Please circle the number (0-10) that best describes how much distress you've had during the past week, including today.

Extreme Distress — No Distress

10 9 8 7 6 5 4 3 2 1 0

Please check which of the following issues have been a problem for you in the past week, including today?

Emotional Concerns
❑ Anger
❑ Depression
❑ Fears
❑ Nervousness
❑ Sadness
❑ Spiritual/Religious concern
❑ Worry
❑ Less interest in activities

Physical Concerns
❑ Appearances
❑ Bathing/dressing
❑ Concentration/Memory
❑ Constipation/ Diarrhea
❑ Eating
❑ Fatigue/Sleep
❑ Nausea
❑ Pain
❑ Tingling hands/feet

Practical Concerns
❑ Child Care
❑ Housing
❑ Insurance/financial
❑ Transportation
❑ Treatment Decisions
❑ Work or school

Family Concerns
❑ Dealing with children
❑ Dealing with partner
❑ Dealing with other family
❑ Family/ Other health issues

❑ Other Concerns:

Release Statement

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:

❑leave voice messages ❑not leave voice messages ❑ speak with anyone who answers the phone(s)

❑speak only with the following: (please list individual names) _____

Additional instructions: _____

I consent to permit the staff of Cancer Services to provide assistance and support services to me and/or my family members to help with the referenced client's cancer diagnosis. 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. 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.

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:_____

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Source of Income (social security, pension, employment, etc.):	Number of people in household:

Medical Information

Type of Cancer:	Date of Diagnosis: / /	Date of Surgery: / /
Oncologist:	Radiologist:	Other Attending Physician:
Receiving chemotherapy? ❑ Yes ❑ No	Receiving radiation? ❑ Yes ❑ No	Other Treatment?
Diabetic ❑ Yes ❑ No	Medical Insurances (s):	Prescription Coverage? ❑ Yes ❑ No

Other Notes:

Kids Kare

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

Name:	DOB:	Name:	DOB:
Name:	DOB:	Name:	DOB:
Name:	DOB:	Name:	DOB:

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:_____