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 SOCIAL WORKER, PHYSICIAN, PHYSICIAN ASSISTANT, NURSE, NURSE PRACTITIONER OR DIETITAN			
Last Name: First Name: Middle Initial:		Address:	
Patient Date of Birth:	Patient Marital Status:	Patient Sex:	Patient Phone #:

Date of Referral:	Referring Healthcare Provider – Name, Credentials & Phone Number	
Diagnosis & Date of Diagnosis:	Referring Facility:	Name of Physician(s):

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

- ☐ Nutritional Supplement
- ☐ Medical Supplies
- ☐ Medical Equipment
- ☐ Wig Boutique
- ☐ Mastectomy Bras/Prostheses
- ☐ Financial Assistance - less than 250% of FPL
- ☐ Case Management
- ☐ Counseling
- ☐ Support Groups
- ☐ Children and Family Support
- ☐ Exercise Groups (Aerobics and Yoga)
- ☐ Mind-Body Skills
- ☐ Healing Arts

Nutritional Supplement: By completing this section, you are confirming that your patient needs nutritional supplement based on the cancer diagnosis. A physician, physician assistant, nurse, nurse practitioner, or dietician must complete this section.

☐ 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:

Updated 8/20/19