**Community Referral for Cancer Support Services**

Welcome to the National Rural Oncology Collaborative Cancer Support Services Program. This is the referral form you fill out in order to learn more about cancer support services through Breckinridge Health, Inc. All referrals will be processed promptly by Leslie Kennedy and our dedicated care managers. We look forward to serving you with the highest level of care.

Steps for Completing a Referral for Cancer Support Services

1. Use the Form “**Cancer Support Services Referral Form”**

2. Please complete all required information and turn in the form at the Business Office window. They will direct your form to Leslie Kennedy, Chief Nursing Officer for Breckinridge Health, Inc.

3. Your referral form will be faxed by Leslie Kennedy to the NROC Care Manager at 1-877-206-7736 to notify the NROC care manager of your interest in cancer support services.

4. The NROC Care Manager will reach out to you promptly to schedule your orientation appointment.

Thank you for your interest in the National Rural Oncology Collaborative at Breckinridge Health, Inc. We look forward to serving you with the highest standards for cancer support services.

**CANCER SUPPORT SERVICES REFERRAL FORM—COMMUNITY**

Date: \_\_\_\_\_\_\_\_\_\_\_

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI:\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender Orientation: ( ) Male ( ) Female ( ) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

Food or Environmental Allergies: ( ) NKDA \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of cancer do you have?

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

What stage is your cancer? \_\_\_\_\_\_\_\_ When were you diagnosed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to learn more in group orientation or 1:1 orientation meeting? (\_\_\_)group (\_\_\_) 1:1

**PRIMARY CAREGIVER/CARE PARTNER INFORMATION (may be a family or friend)**

Last Name: \_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI:\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_

Gender Orientation: ( ) Male ( ) Female ( ) Other Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH PROVIDER INFORMATION**

Physician Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(For Office Use) NPI #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (For Office Use) Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Office Use Only:* Please fax to the NROC Toll-Free Fax Line at **1-877-206-7736**.