CANCER SUPPORT COMMUNITY
GREATER CINCINNATI - NORTHERN KENTUCKY
Formerly The Wellness Community

Referral Form

fax to: 513-791-8239 or
email to: kschoen@cancer-support.org
Attention: Kelly Schoen LISW-S

FOR PATIENTS AFFECTED BY CANCER

Please complete or ask the patient to complete this form, and fax or email it to us at the number listed above. Once the form is received, we contact the patient. Information provided will remain confidential; however, names will be added to our patient services mailing list. For any questions, please contact us at (513) 791-4060.

Patient Information: ***(Please print)***

Date: _____

Last Name: _____ First Name: _____

Address: _____ City/Zip: _____

Phone: _____ Fax: _____

E-Mail: _____ County: _____

If child, list parent/guardian name: _____

Patient's Date of Diagnosis: _____ Patient's Date of Birth: _____

Diagnosis: _____

Disease status: ❑ Newly Diagnosed ❑ In Treatment ❑ Remission ❑ Relapse

Healthcare professional making the referral:

Name: _____ Phone: _____

Social Worker/Nurse: _____

Institution: _____ Patient's Physician: _____

Additional Comments: _____

Patient confidentiality agreement:

To insure patient privacy protection as part of the Health Insurance Portability and Accountability Act (HIPAA), & to provide patients with control over what personal information is used & disclosed, I,_____ agree to have the above information released to Cancer Support Community.

*****Patient's or Guardian's Signature:*** _____

For further information please contact us:
Cancer Support Community
4918 Cooper Road
Cincinnati, Ohio 45142
513-791-4060
kschoen@cancer-support.org