Physician Referral Form

Patient Name:___________________________________ Patient DOB: ___________________________

Phone: ____ Does patient live in Laurens County? Y or N

The above patient has applied to the Laurens County Cancer Association for assistance.
Please complete the following information:

1. Does this patient currently have cancer? ☐ Yes ☐ No (If yes, please complete the sections below)
2. Cancer Diagnosis ____
3. Prognosis ____ Date Diagnosed ______________

THIS SECTION MUST BE COMPLETED

4. Is this patient on Chemo? Y / N ☐ Oral OR ☐ Infusion

   Frequency _____________________

Start Date _________________ Estimated End Date ________________

5. Is this patient on Radiation? Y / N

   Frequency: ___________________________

Start Date __________________ Estimated End Date _______________

Last oncology visit? ____

If you have any questions about this patient or our services, please call 864-358-7376

Once completed, please fax form to 864-833-3997 or email to lccafrontoffice@gmail.com

Physician Name [printed] ____

Physician Signature ____ Date _________________________