



TOLL FREE FAX: 1.866.562.1836

Patient Referral Form

ACS Staff Use Only – Designate Channel
_____ Onsite
_____ Local Office

Name (First/Last/MI) _____		E-mail _____	
Mailing Address _____		Apartment/Suite _____	
City _____	State _____	Zip Code _____	
(_____) _____ - _____ Home Phone	Best time to call: <input type="checkbox"/> AM <input type="checkbox"/> PM	Leave Message: <input type="checkbox"/> Yes <input type="checkbox"/> No	
DOB (M/D/Y) ____/____/____	Age _____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (specify) _____			
Race/Ethnicity: <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> White <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other			
Cancer Diagnosis (site) _____		Date of Diagnosis (M/Y) _____	Recurrence: <input type="checkbox"/> Yes <input type="checkbox"/> No
Insurance: <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private Insurance <input type="checkbox"/> Military <input type="checkbox"/> Uninsured			
Alternate contact on behalf of patient: <input type="checkbox"/> Family Member <input type="checkbox"/> Caregiver <input type="checkbox"/> Health Professional			
Contact Name (First/Last/MI) _____			
Phone (_____) _____ - _____	Best time to call: <input type="checkbox"/> AM <input type="checkbox"/> PM	Leave Message: <input type="checkbox"/> Yes <input type="checkbox"/> No	

PATIENT CONSENT (HIPAA): I authorize my healthcare provider to share this information with the American Cancer Society.

REQUIRED LEVEL OF FOLLOW UP – Select Most Appropriate

- STANDARD FOLLOW UP: Patient will receive free information within 4 days and a follow up call within 3-4 weeks.
- PRIORITY FOLLOW UP: Patient will receive free information and a follow up call within 4 days.
- PRIORITY FOLLOW UP: For hope, comfort and support. No print material at this time. Follow up call within 3 days.

PLEASE CHECK ALL THAT APPLY:

Assistance
 Transportation
 Lodging
 Look Good...Feel Better
 Reach to Recovery
 Smoking Cessation
 Other (Enter comments below)

COMMENTS:

Form completed by: _____ Email _____ Date _____

Nassau Radiologic Group PC - Long Island Radiation Therapy
6 Ohio Dr Ste 103, New Hyde Park, NY 11042

Treatment Center ID:
1-VHZ5L9