Community Cancer Center

Community Outreach Program

# Referral Form

**FAX TO: Community Cancer Center | attn: Angelia Freeman (541) 672-9483**

## PROGRAM SELECTION

Referring Office:_____ Phone:_____ Date of Referral:_____

Which program(s) best suits your patient needs:

- ☐ Living Well with CHRONIC PAIN
- ☐ Living Well with CHRONIC CONDITIONS
- ☐ Living Well with CANCER: Triving & Surviving
- ☐ Freshstart - **TOBACCO CESSATION** Classes
- ☐ the Next Step - **TOBACCO CESSATION** Weekly Group Support Meetings

*A member of our team will contact your patient and arramge program registration.*

## PATIENT INFORMATION

Patient Name:_____ DOB:_____

PCP | Physician:_____ Insurance Type: N/A

Patient Mailing Address:_____

_____ _____

City Zip

Home Phone:_____ Cell Phone:_____

Email: _____

Caregiver Name (if applicable):_____ Caregiver Phone:_____

## GENERAL INFORMATION

Reason for referral: _____

Comments or considerations:_____

_____

_____

- ☐ Yes, patient is aware of the referral.
- ☐ No, patient is NOT aware of the referral.
- ☐ Yes, patient was given a brochure or information about the referred program.
- ☐ No, patient was NOT given a brochure or information about the referred program.

## CCC OUTREACH

Date referral received:_____ Referring office ACK: ☐ Yes ☐ No Date:_____

Referral Accepted? ☐ Yes ☐ No Explain: _____

Patient Contact Date:_____ Program(s) Enrolled: ☐CPSMP ☐CCSMP ☐CTSSMP ☐FSTC ☐NSTC ☐CSG ☐ Other: _____

Notes:_____

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