CANCER ASSOCIATION OF SPARNTANBURG & CHEROKEE COUNTIES, INC.

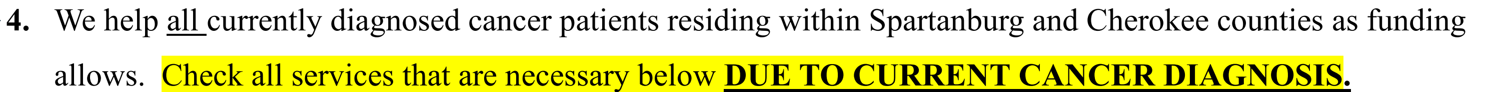
PHYSICIAN REFERRAL FORM: Please complete entirely.

139 S. Dean St., Spartanburg, SC 29302 864-582-0771
Hours: M-TH 8:30 am – 5:30 pm   F 8:30 am – 12:30 pm
Return form to: jbillings@cancerassociation.org or FAX to: 864-583-6123

Patient Name ______________________________ Patient DOB: ______________

Treating Physician ______________________ Assigned Navigator __________________

1. Does this patient currently have a malignancy? ☐ Yes ☐ No (If yes, please complete sections below)
2. Cancer Diagnosis Name(s) ____
3. Date Diagnosed ____________________ Date last seen by you ________________



4. We help all currently diagnosed cancer patients residing within Spartanburg and Cherokee counties as funding allows. Check all services that are necessary below **DUE TO CURRENT CANCER DIAGNOSIS.**

Nutritional Supplements: ☐ Boost Regular 240 calories ☐ Boost Plus 360 calories ☐Glucose Control (diabetics only)

☐ Treatment Transportation/Fuel Card (also complete #5) ☐Wig ☐Counseling ☐ Incontinence supplies

☐Ostomy Supplies (with no insurance coverage) ☐ Equipment (if available) ☐ **NO SERVICES RECOMMENDED**

5. Please complete the following for **fuel card** assistance only. **Oral treatment does not qualify.**

Treatment	Oral or Infusion	# Trips to facility per month for tx	Start Date	End Date	Treatment Location
Chemotherapy	☐ Oral ☐ Infusion	________	________	________	☐380 Serpentine Dr. ☐2759 SC-14 ☐2400 Boiling Springs Rd. ☐724 Hyatt St. ☐340 Medical Pkwy ☐Other: ______________
Immunotherapy	☐ Oral ☐ Infusion	________	________	________	☐380 Serpentine Dr. ☐2759 SC-14 ☐2400 Boiling Springs Rd. ☐724 Hyatt St. ☐340 Medical Pkwy ☐Other: ______________
Radiation	n/a	________	________	________	☐380 Serpentine Dr. ☐2759 SC-14 ☐340 Medical Pkwy ☐Other: ______________

Date ________________ Authorized Signature ____________________

Person completing form: ________________________________