LAURENS COUNTY CANCER ASSOCIATION
Hope in Community

Office Location
1337 Medical Ridge Road
Clinton, SC 29325
Office: 864-833-3976
Fax: 864-833-3997
Cell: 864-872-5464

Mailing Address
P.O. Box 0006
Clinton, SC 29325

Email:
Lccancerassoc@gmail.com

Physician Referral Form

Patient Name: _____ Patient DOB: _____/_____/_____

Patient Address: _____

Dear Dr. _____:

The above patient has applied to the Laurens County Cancer Association for assistance. In order for us to help your patient, please complete the following information:

1. Does this patient currently have a malignancy? ☐ Yes ☐ No (If Yes, please complete sections below)
2. Cancer Diagnosis Name(s)_____
3. Prognosis _____ Date Diagnosed _____ Date last seen by you _____
4. Is this patient on: ☐ Chemo? Choose One: ☐ Oral ☐ Infusion Frequency _____

   Start Date _____ Estimated End Date _____

   ☐ Radiation? Frequency _____

   Start Date _____ Estimated End Date _____
5. What medications (with dosage) have been prescribed for this patient for their cancer treatment only? (please list clearly) --attach information on separate sheet if necessary

   _____

   Length of prescription(s) (how long will patient take) _____ Estimated End Date _____/____/_____

*******IMPORTANT**** THIS SECTION MUST BE COMPLETED**

We help all currently diagnosed cancer patients within Laurens County as funding allows.

Please check all necessary services below:

Nutritional Supplements ☐ One can per day ☐ Two cans per day ☐ Other _____

Special Dietary Needs: ☐ Diabetic ☐ Tube-Feeding ☐ Liquid Diet ☐ No dietary restrictions

☐ Treatment Transportation Allocation **(during chemo/radiation only-must complete section #4 above)**

☐ Cancer Prescription Allocation **(must complete both sections of #5 above)**

☐ Ostomy Supplies ☐ Wig ☐ Bra ☐ Breast Prosthesis ☐ Equipment (beds, walkers, etc.)

☐ Home Care Supplies (diapers, bed pads, etc.) ☐ **NO SERVICES RECOMMENDED**

Thank you for your prompt reply. We appreciate your support. Feel free to recommend any of your other currently diagnosed cancer patients needing services to our office.If you have any questions about this patient or our services, please call 864-833-3976. **Once completed please fax this form to 864-833-3997.**

Physician Signature _____ Date_____