CANCER SUPPORT COMMUNITY
CENTRAL NEW JERSEY

PROVIDER REFERRAL FORM

Send to: centralnj@cancersupportcnj.org

Cancer Support Community Central NJ is a partner of your healthcare provider. Our services are offered to individuals affected by cancer at no charge thanks to the generosity of our donors and funders. All information is kept strictly confidential.

CONTACT INFORMATION

Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth:_____/_____/_____

Address: _____ City: _____ State: _____ Zip Code: _____

Email: _____

Primary Phone Number: _____ Type (Home, Work, Mobile): _____

DIAGNOSIS INFORMATION

Please complete the following:

Cancer Diagnosis:_____

Diagnosis Dates	**Treatment Stage**	**Please Indicate**
Newly Diagnosed:_____	Active ____	Early Stage___
Recurrent:_____	Post ____	Metastatic ___

Institution: _____ **Person Referring:**_____

Other Special Circumstances (i.e. language):_____

_____

TYPE OF CONSULT

Please Check All that Apply:

_____Education/Information
_____Family/Caregiver Support Services. Indicate ages of children if applicable:_____
_____Health and Wellness (i.e. yoga, meditation, exercise, Reiki)
_____Individual Counseling
_____Nutrition Education
_____Open2Options (Decision Support Program)
_____Pediatric Support (including financial assistance)
_____Resource Navigation and Referral (i.e. DME, Wigs, Transportation, Psychiatry)
_____Support Group
_____Survivorship Programming

I authorize my provider to disclose the protected health information described above to Cancer Support Community CNJ (CSCCNJ), and I approve CSCCNJ to initiate follow-up with me directly. I understand that CSCCNJ may fax this form back to the practice office to indicate only whether the referral was made and that there was follow-up. I am aware that, under N.J.S. 45:14B-28, I may refuse to permit the disclosure of confidential communications between me and my physician under many circumstances. I knowingly waive, for the above purposes only, whatever right of confidentiality I may have. I also am aware that I may revoke this authorization at any time and that, while my revocation will not affect disclosures of information that occurred prior to the revocation, it will be effective as to subsequent requests for disclosure

The following individual received verbal approval for this referral.
Patient or Personal Representative _____Date_____
Provider Name _____

Cancer Support Community CNJ **has __ has not __** made contact with the individual **on __as of __** _____/_____/_____.