Connect with The Gathering Place

Support provided free of charge for individuals & families coping with the impact of cancer in their lives

Please complete, or ask the patient to complete, the following information and send to the fax or email below. Once received, a staff member from The Gathering Place will connect with the patient. Patient information provided will remain confidential; however names will be added to our mailing list to receive information about our free programs and services. **Patients can also self-refer to The Gathering Place**.

Patient's Full Name:____

Patient's Address:________________________________ City& Zip Code:____________________

Phone:________________________ Email:____

If minor, parent/guardian First and Last Name:____

Type of Cancer:____________________________ Date of Diagnosis:__________________________

Patient/Caregiver would like help with:

- □ Emotional Wellness
- □ Nutritional Wellness
- □ Physical Wellness
- □ Fitting for a free wig
- □ Support for family
- □ Support for children/teens or grandchildren
- □ Understanding diagnosis, treatment options, side-effects and local and national resources
- □ Practical Concerns: medical bill questions; end-of-life care planning; legal consultations
- □ Survivorship (support after cancer treatment ends)

Healthcare Professional making referral:

Name:________________________________ Discipline:_____________ Phone:__________________

Institution:_____________________________ Email:____

Additional Comments:____

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Patient Confidentiality Agreement

To ensure patient privacy protection as part of the Health Insurance Portability and Accountability Act (HIPAA) and to provide patients with control over what personal information is used and disclosed, I, ______________________________ , agree to have the above information released to The Gathering Place. *(patient's name)*

By signing this form, I am also giving permission for The Gathering Place to inform my healthcare provider when I have connected with The Gathering Place.

Signature of Patient/Guardian____ Date:_______________

Please fax this form to 216.595.9581 or scan and email to Betsy Kohn at kohn@touchedbycancer.org

The Gathering Place is a caring community that supports, educates and empowers individuals and families coping with the impact of cancer in their lives through programs and services provided free of charge. www.touchedbycancer.org · 216.595.9546