LEUKEMIA & LYMPHOMA SOCIETY®
fighting blood cancers

Fax Referral Form

FOR PATIENTS WITH LEUKEMIA, LYMPHOMA, MYELOMA OR OTHER BLOOD CANCERS
Please fax to: South Carolina Chapter at 803-731-4066

Please complete or ask the patient to complete this form and fax it to the Leukemia & Lymphoma Society South Carolina Chapter office fax number listed above. Once received, we will call the patient within 7-10 business days and send printed or emailed resources as needed. Information provided will remain confidential; contacts will be added to our database for future updates and announcements on related services. For any questions, please contact the South Carolina Chapter at 800-613-0550 or visit www.lls.org/sc.

***Patient Information:* (Please print)** Date: _____

Last Name: _____ First Name: _____

Address: _____ City/State/Zip: _____

Phone: _____ Email: _____

Patient's Date of Birth: _____ Gender (circle): M F

Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other

Patient's date of diagnosis: _____ If child, list parent/guardian name: _____

***Diagnosis:* (Check one of the following)**

☐ Acute Lymphocytic Leukemia	☐ Hairy Cell Leukemia	☐ Myeloma
☐ Acute Myelogenous Leukemia	☐ Non-Hodgkin Lymphoma	☐ Myelodysplastic Syndrome
☐ Chronic Lymphocytic Leukemia	☐ Hodgkin Lymphoma	☐ Acute Promyelocytic Leukemia
☐ Chronic Myelogenous Leukemia	☐ Waldenstrom's	☐ Other _____

Disease status: ☐ Newly Diagnosed ☐ In Treatment ☐ Remission ☐ Relapse ☐ Watch and Wait

I am interested in (check all that apply):

☐ First Connection ☐ Co-pay Assistance ☐ Disease information ☐ Volunteering

I prefer to receive information in: ❑ English ❑ Spanish ❑ Other: _____

Healthcare professional making the referral:

Name: _____ Phone: _____

Social Worker/Nurse (circle one) or Other: _____

Institution: _____ Patient's Physician: _____

Additional comments: _____

Patient confidentiality agreement:

To insure patient privacy protection as part of the Health Insurance Portability and Accountability Act (HIPAA), & to provide patients with control over what personal information is used & disclosed, I, _____, agree to have the above information released to The Leukemia & Lymphoma Society.

***Patient's or Guardian's Signature:** _____