

Fax Referral Form

Please fax to: *Desert Mountain States Chapter 602.567.7601*

FOR PATIENTS WITH LEUKEMIA, LYMPHOMA, MYELOMA OR OTHER BLOOD CANCERS

Please complete or ask the patient to complete this form, and fax it to your local Leukemia & Lymphoma Society office fax number listed above. Once received, we will send a packet of information. Information provided will remain confidential; however, names will be added to our patient services mailing list. For any questions, please contact the (*chapter name*) listed below.

Patient Information: (Please print)

Date: _____

Last Name: _____ First Name: _____

Address: _____ City/Zip: _____

Phone: _____ Fax: _____

E-Mail: _____ County: _____

If child, list parent/guardian name: _____

Patient's Date of Diagnosis: _____ Patient's Date of Birth: _____

Diagnosis: (Check one of the following)

- | | | |
|---|---|---|
| <input type="checkbox"/> Acute Lymphocytic Leukemia | <input type="checkbox"/> Hairy Cell Leukemia | <input type="checkbox"/> Myeloma |
| <input type="checkbox"/> Acute Myelogenous Leukemia | <input type="checkbox"/> Non-Hodgkin's Lymphoma | <input type="checkbox"/> Myelodysplastic Syndrome |
| <input type="checkbox"/> Chronic Lymphocytic Leukemia | <input type="checkbox"/> Hodgkin's Disease | <input type="checkbox"/> Acute Promyelocytic Leukemia |
| <input type="checkbox"/> Chronic Myelogenous Leukemia | <input type="checkbox"/> Waldenstrom's | <input type="checkbox"/> Other _____ |

Disease status: Newly Diagnosed In Treatment Remission Relapse

Healthcare professional making the referral:

Name: _____ Phone: _____

Social Worker/Nurse: _____

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:** _____

For further information please contact the chapter:

Desert Mountain States Chapter
3877 N 7th St., Suite 300, Phoenix, AZ 85014
Phone: 602.567.7599 Fax: 602.567.7601