the wellness community®
greater st. louis
cancer support, education and hope

**Staenberg Family Foundation Cancer Services**
**(Formerly Miriam Cancer Services)**

# REFERRAL FOR ASSISTANCE

**PATIENT INFORMATION** ☐ **Female** ☐ **Male** **TODAY'S DATE** ____________________

**NAME:** ______________________________________________ **PHONE:** ________________________

**ADDRESS:** ____________________________________________________________________________

**CITY:** ______________________________________ **STATE:** ____________ **ZIP:** ____________________

**CANCER DIAGNOSIS:** ____________________________ **ONCOLOGIST:** ______________________________

**ETHNICITY:** ☐ Caucasian ☐ African American ☐ American Indian/Alaskan Native
☐ Hispanic/Latino ☐ Asian Pacific Islander ☐ Other

**The following information is MANDATORY. We do not disqualify applicants based solely on income level.**
**ANNUAL HOUSEHOLD INCOME:** ☐ Under $25,000 ☐ $25,000 - $49,000 ☐ $50,000 - $99,999 ☐ $100,000+
**NUMBER OF INDIVIDUALS IN HOUSEHOLD:** ________________________

**Is this person financially in need of this service?** ***(This means that this person could not or would not be able to obtain this item(s) on his/her own without encountering significant financial strain.)***
☐ **Yes** ☐ **No** **referring professional initial to verify** ________________

**CAREGIVER CONTACT INFORMATION (IF PATIENT UNAVAILABLE)**

NAME: ________________________________________________ PHONE: __________________________

RELATIONSHIP TO PATIENT: __________________________________________________________________

**TYPE OF ASSISTANCE REQUESTED**

**DELIVER PRODUCT(S) TO PATIENT?** ☐ **YES** ☐ **NO**

Breast Prosthesis Lymphedema Sleeves
Bra Wig
Nutritional supplement (specify Type): ________________________________ Flavor:____________________
Incontinence Products (specify): ______________________Pt .Wgt.__________ Size (if applicable): __________
Other Medical Supplies (specify): ______________________________________________________________

**SOURCE OF REFERRAL**

Health Care Professional Requesting Services (Print): ______________________________________________

Title/Position______________________________________________________________________________

Email: ____________________________________________ Phone: ____________________________

Hospital/Organization:________________________________________________________________________

Address: __________________________________________________________________________________

City: ____________________________________________ State: ____________ Zip: ________________

Does patient have health insurance? ☐ YES ☐ NO Insurance ID #: __________________________________

Insurance Company: ______________________________________ Phone: ____________________________

Patient Date of Birth: ______________________ Is there full or partial insurance coverage for this item? ☐ YES ☐ NO

If yes, please provide details: ______________________________________________________

Is this patient in hospice? ☐ YES ☐ NO Name of Hospice: __________________________________

**By signing below, you attest that (a) the above item(s) is/are NOT covered by the Medicare or Medicaid hospice benefit, or similar private insurance hospice benefit if applicable AND (b) that this person is in financial and medical need of this item(s).**

Signature of Health Care Professional: _______________________________________________________

Fax or Mail To: **The Wellness Community of Greater St. Louis**
**1058 Old Des Peres Rd.**
**St. Louis, Mo 63131**

**Phone: 314-238-2000**
**FAX: 314-909-9900**