



CONFIDENTIAL

Client Information and Support Referral Form

Client Consent, please check all that apply:

- I consent to be referred to and contacted by the Canadian Cancer Society's Cancer Information Service
- I consent to have the Canadian Cancer Society leave a message at my contact number(s)

I understand that the Canadian Cancer Society may contact me for additional information and that the information contained on this form, used to provide information services, will be recorded and securely stored by the organization. The Canadian Cancer Society will not use the information on this form for another purpose or share it with any external individual/organization without my expressed consent. For information about the Canadian Cancer Society privacy policy, go to www.cancer.ca, e-mail info@pei.cancer.ca or call 1 800 566-4007.

Client Signature (required): _____ Date: _____

Please PRINT CLEARLY

Client's Name _____ Client's Year of Birth _____

Client's Address _____ City/Town _____ Province _____ Postal Code _____

Home Phone _____ Other Phone _____

Client prefers service in: English French Other (please indicate): _____ (Interpreter service available)

Best time to contact the client: AM PM

Date of Surgery (if applicable) _____ Initial contact should occur: Pre-op Post-op

Treatment (Please check all that apply): Chemo Radiation Unknown at this time None
 Other: _____

Cancer Diagnosis (please include details): _____

Name of Healthcare Professional making referral _____	Telephone number _____
Discipline of Health Professional referring client:	<input type="checkbox"/> Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Pharmacist <input type="checkbox"/> Dentist <input type="checkbox"/> Patient Navigator <input type="checkbox"/> Radiation Therapist <input type="checkbox"/> Hygienist <input type="checkbox"/> Chaplain <input type="checkbox"/> Social Worker <input type="checkbox"/> Other: _____