Children's Cancer PARTNERS OF THE CAROLINAS™
Supporting Families Through the Journey

New Family Referral Form

Date of Referral: _____
Hospital: _____

PATIENT

Patient Name: _____ DOB: _____ Age: ____ Gender: _____
Diagnosis: _____
Date of Initial Diagnosis: _____ Date of Relapse: _____
How long will patient be in treatment? _____
Details of treatment plan? If not in treatment, please explain:
_____
_____
Address: _____ Address Line 2: _____
City: _____ State: _____ Zip: _____ County: _____

FAMILY

Caregiver #1: _____ Role (mom, dad, etc.): _____
Phone: _____ Email address: _____
Caregiver #2: _____ Role (mom, dad, etc.): _____
Phone: _____ Email address: _____
Preferred Language: _____ Sibling(s) Name(s): _____
_____

Is family interested in CCP mileage/meal/parking reimbursements? □ yes □ no
Any specific needs (out of state travel, urgent requests, etc.)? _____
_____

Social Worker Name: _____ SW Phone: _____
Social Worker Signature: _____ Date: _____

*Parent Signature (patient sign if age 18+) _____ (see below)
**By signing this form, I authorize Children's Cancer Partners of the Carolinas to receive information from St. Francis Cancer Center and to share information with St. Francis Cancer Center about myself (if age 18+)/my child for the purposes of ongoing family support and care coordination.*

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