Patient Referral Form

FOR KERN COUNTY AREA FAMILIES WHO ARE RECEIVING TREATMENT FOR PEDIATRIC LEUKEMIA, LYMPHOMA OR OTHER BLOOD CANCERS

Please complete this form and e-mail or mail it to the Tigerfight Foundation at the e-mail or physical address noted below. Once received, we will notify you with a confirmation by e-mail within 10 days. Applications will be reviewed by our board and monetary disbursements will be provided to accepted applications on a quarterly basis. Information provided will remain confidential; however, names will be added to our patient services mailing list. For any questions, please contact the Tigerfight Foundation by phone at (661) 200-5655 or email tigerfight@tigerfight.org.

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

Date: ______________________

Last Name: ____________________________________ First Name: ______________________________________

Address: ____ City/Zip: ______________________

Phone: ____ Fax: ______________________________

Guardian's e-mail: ____ County: KERN ______________________

Guardian's name: ____

Patient's Date of Diagnosis: ___________________________ Patient's Date of Birth: ________________

Diagnosis:

____

Treatment status: ❑ Newly Diagnosed ❑ In Treatment ❑ Remission ❑ Relapse

Healthcare professional making the referral:

Name: ____ Phone: ______________________________

Social Worker/Nurse: ____

Institution: ____ Patient's Physician: ______________________

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 Tigerfight Foundation.

*****Guardian's Signature:*** ____

For further information please contact Tigerfight Foundation:

4208 Rosedale Highway, Suite 302-200
Bakersfield, CA 93308
tigerfight@tigerfight.org