

CANDLELIGHTERS PATIENT & FAMILY SERVICE REQUEST

CHILD INFORMATION

Today's Date: _____

Diagnosed Child's Full Name: _____ Sex: _____
Date of Birth: ____/____/____ Social Security # XXX-XX - ____ Race: _____
Diagnosis: _____
Date of Diagnosis: ____/____/____ If Deceased/ ____/____/____
Doctor's Name: _____ Phone: _____
Clinic/Hospital: _____
Social Worker: _____ Phone: _____
Insurance Company: _____ Policy# _____
Date of Bone Marrow Transplant: ____/____/____ Location: _____
Date of Final Chemo: ____/____/____ School: _____

PARENT INFORMATION

Parents Last Name: _____ Marital Status: _____ Child Lives With _____
Fathers First Name: _____ Mothers First Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____ - _____ County _____
Telephone: (Home Phone#) () _____ - _____
(Father's Work#) () _____ - _____ (Mother's Work#) () _____ - _____
Additional Contact _____ (Phone #) () _____ - _____
Do You Own a Computer? ___ Yes ___ No Do You Own A Cell Phone? ___ Yes ___ No
E-MAIL ADDRESS if available: _____

SIBLING INFORMATION

<u>List all Siblings</u>	<u>Date of Birth</u>	<u>Sex</u>
_____	_____	Male/Female
_____	_____	Male/Female
_____	_____	Male/Female
_____	_____	Male/Female
_____	_____	Male/Female
_____	_____	Male/Female

Primary Language: English ___ Spanish ___ Italian ___ Other _____

Other Information: _____

Candlelighters of Southwest Florida, Inc. may forward this information to other health agencies including the American Cancer Society, Candlelighters Childhood Cancer Foundation, and The Leukemia Society of America who may offer additional services to benefit the patient.

Parent Signature required for Services _____

May we include you in the Candlelighters Parent Directory? ___ Yes ___ No

Return form to: Candlelighters of Southwest Florida, Inc.

9981 S HealthPark Drive

Fort Myers, Florida 33908

(239) 432-2223 or (800) 738-3588

www.CandlelightersSWFL.org OR info@CandlelightersSWFL.org