New Patient Needs Survey

Your health care provider believes the free services and information provided by the Community Cancer Center could be valuable for you and your family in dealing with your cancer experience. Please complete this form and the Community Cancer Center staff will contact you directly about the services and resources you checked below. How can the Community Cancer Center Help You?

I would like more information on:

- ❑ Transportation Assistance
- ❑ Financial Assistance
- ❑ Applying for Disability
- ❑ Assistance in My Home
- ❑ Lodging Assistance
- ❑ Nutrition
- ❑ Communication with Family/Friends
- ❑ Communication with My Doctor
- ❑ Make-up Sessions with Licensed Cosmetologist
- ❑ One-on-One Support from Survivor of Same Cancer
- ❑ Wigs/ Hats/ Turbans
- ❑ Prosthesis Resources
- ❑ About My Cancer (specify _____)
- ❑ Other (specify _____)

Presently, are you receiving services from any of the following programs?

- ❑ Community Health Care Clinic
- ❑ IL Breast & Cervical Cancer Program
- ❑ Scott Health Resources
- ❑ W.I.N.G.S.
- ❑ Other: _____

Do you have Advance Directives (Living Will & Power of Attorney for Health Care)?

❑ YES - *If Yes*, is there a copy in your medical record ❑Yes ❑No

❑ NO - *If No*, would you like to obtain these forms ❑Yes ❑No ❑Not Sure

Are you interested in obtaining information about Support/Educational Groups?

❑YES – *If Yes, please check your group preference(s):*

- ❑ Breast Cancer
- ❑ Cancer (All types)
- ❑ Children/Teens
- ❑ I Can Cope® *for the Newly Diagnosed Patient*
- ❑ Leukemia/Lymphoma/Myeloma/Hodgkin's
- ❑ Prostate Cancer
- ❑ Caregivers – Strength for Caring Class
- ❑ Other_____

❑NO, not at this time

Do you anticipate that your illness/treatment will create Spiritual or Pastoral Care concerns for you or your family?

❑ Yes — *If Yes,* would you like a referral to clergy? ❑ Yes ❑No, I have my own clergy

❑ No, not at this time

Would you like to receive our monthly Community Cancer Center Newsletter and be notified about our upcoming programs & events? ❑By Mail Mailing Address: _____

❑By E-mail Email Address: _____

Name: _____Today's Date: _____

Type of Cancer:_____ Date of Birth: _____ PH# _____

Please return this form to the Receptionist. Thank You!

Source: Community Cancer Center, Normal, IL.