



INTAKE & REFERRAL FORM

Referring Agency: _____ Date: _____

Agency Contact/ Case Mgr/ Navigator: _____ Phone: _____

Email address: _____ Fax: _____

Client name: _____ Phone: _____

Address: _____ Apt #: _____ Cell: _____

City: _____ Zip: _____ DOB: _____ E-mail: _____

Client Primary Language: English Spanish Chinese: Mandarin / Cantonese Other: _____

MEDICAL DIAGNOSIS

Type of cancer: _____ Date of Diagnosis: _____

Staging/significant information (grade/hormone receptors, etc): _____

Does your client have lymphedema (please circle one)? Yes No

Recommended protocol (in suggested order of treatment):	Date Started:	Date Finished:
_____	_____	_____
_____	_____	_____

Other medical conditions: _____

Social Service/Other concerns: _____

Primary Care Facility: _____ Primary Care Physician: _____

Medical Record #: _____

Oncology Care Facility: _____ Oncologist: _____

REFERRAL INFORMATION - PLEASE CIRCLE RESPONSES - IF NOT DISCUSSED CHOOSE "N/A"

Has your client expressed interest in CAM (complementary/alternative medicine): Yes No N/A

Massage/Body Work: Yes No N/A Acupuncture: Yes No N/A

Therapeutic Imagery: Yes No N/A Homeopathy: Yes No N/A

DOES THE CLIENT CURRENTLY HAVE: Medi-Cal: Yes No Medicare: Yes No Private Insurance: Yes No

Employment: Yes No Other sources of income: Yes No Total monthly Household Income: \$ _____

PREVIOUS REFERRALS (CIRCLE ALL THAT APPLY): ACS BCEF CancerCare Circulo de Vida Peer Volunteer Project

Open Hand Shanti WCRC BCEF Second Opinion Local Support Groups: _____

Other (ie housing, emergency funds): _____

Thank you, for your referral to Charlotte Maxwell Clinic. We will contact your client as soon as possible. Please remember that due to the high volume of request for our services we cannot guarantee when your client will be scheduled. If you have any concerns or questions, please call our Client Services Dept. at (510) 601-7660 ext. 6