2880 NW Stewart Parkway
Suite 202
Roseburg, OR 07471
(541) 440-9409

Date Received ___________

REQUEST FOR SERVICES

*** All lines must be completed to be processed for consideration ***

Patient Name:____DOB:______________________
(Please print)

Address: ____

Phone:___________________Cell Phone:________________E-Mail Address: _______________________

Employer: ____

Do you have health insurance? Yes___No___Are you a Veteran? Yes No___Number in Household:_______

How did you hear about Douglas County Cancer Services?_______________________________________

*** Income information MUST be completed in its entirety for consideration of your request ***

Total Monthly Household Income: Salary/Wages:________SS:_________SSI:_________VA: _______

Other Income: *(Please explain)* ____

Please tell us how your diagnosis affects your monthly income:

____

____

____

*** Service(s) Requested: (circle all that apply or specify as requested) ***

Wig/Turban/Hat________ Breast Prosthesis__________ Gas Card $_________ Food Card$________

Financial Aid *(rent/utilities)* $_________________ Nutritional Supplement____________

Physician Name:____Phone:__________________________

Physician Address: ____

____

Patient Signature ***Date***

** This section to be completed by medical provider only **

Diagnosis: ____

Treatment: Chemotherapy______Radiation______Both______Other___________________________

Treatment Start Date:_______________Estimated Length of Treatment: ______________________

Medical Provider Name Printed ***Signature*** ***Date***

This form may be downloaded at http://dccancerservices.com *and submitted electronically to* dccancerservices@hotmail.com

RFS Form 01/2016