

PATIENT INFORMATION FORM

Children's Leukemia Foundation of Michigan (CLF) provides information, financial assistance, and emotional support to families affected by leukemia, lymphoma, and other malignant or potentially malignant disorders of the blood, bone marrow, and lymphatic system. Our services are free of charge and are available for both child patients and adult patients. Families must complete this form to be eligible for CLF's services. Please print clearly or type. Completed forms should be mailed to CLF at 5455 Corporate Drive, Suite 306, Troy, MI 48098, or faxed to (248) 530-3042. Please call (800) 825-2536 with any questions or concerns.

ABOUT THE PATIENT

Date ____/____/____

General Information

First Name _____ Middle Initial _____ Last Name _____

Address _____ City _____ State _____ Zip _____

County _____ Home Phone () _____ Cell Phone () _____

Where do you want to be contacted? (Please circle) Home Phone Cell Phone

E-mail _____ Birth Date ____/____/____ Gender Male Female

Race (Optional) _____ Marital Status _____ Spouse/Significant Other's First Name _____ Last Name _____

Employed - Employer _____ Unemployed Retired Disabled Student Other _____

Medical & Insurance Information

Diagnosis _____ Diagnosis Date ____/____/____ Bone Marrow/Stem Cell Transplant Date ____/____/____

Treatment Center _____ City _____ State _____

Health Professional Contact _____ Title/Position _____ Phone () _____

Does the Patient Have Health Insurance? Yes (If Yes, Please Continue) No (If No, Please Skip to the Next Page)

Does the Insurance Cover ANY of the Patient's Treatment Costs? Yes No

Does the Insurance Cover ANY of the Patient's Prescription Costs? Yes No

Primary Health Insurance _____ Name of Policy Holder _____

Secondary Health Insurance _____ Name of Policy Holder _____

Does the Patient Have Medicare? Yes No Pending Does the Patient Have Medicaid? Yes (Spend Down? \$ _____) No Pending

COMPLETE IF THE PATIENT IS A CHILD (UNDER 18)

Guardian Information (Only list the address if it is different then the patient's)

Guardian First Name _____ Last Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Contact Phone () _____ E-mail _____

Employer _____

Guardian First Name _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Contact Phone () _____ E-mail _____

Employer _____

COMPLETE IF THE PATIENT IS AN ADULT (18 OR OVER)

Family Contact Person Information

First Name _____ Last Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Contact Phone () _____ E-mail _____

ADDITIONAL FAMILY INFORMATION – CHILD & ADULT PATIENTS

Total Number of People in the Household _____ Children _____ Adults _____ Estimated Annual Family Income \$ _____

For Adult Patients, List Names/Ages of Children Still Living at Home _____

For Child Patients, List Names/Ages of Siblings Still Living at Home _____

How Did Your Family Hear About CLF? _____

I certify that this information is true to the best of my knowledge as of the date indicated below. I understand that Children's Leukemia Foundation of Michigan is a non-profit, community organization. Provision of services is subject to approval by the CLF Board of Directors and may be discontinued at any time with or without notice. CLF will contact me upon receipt of my completed application.

Signature _____ Relationship to the Patient _____ Date ____/____/____

COMPLETION OF THIS PAGE IS OPTIONAL

Please circle the extent to which you agree or disagree with the following statements:

- **I feel like I need more information about the patient's illness and surrounding issues.**

Strongly Disagree Disagree Neutral Agree Strongly Agree

Comments _____

- **The patient's illness has had an effect on our family's financial status.**

Strongly Disagree Disagree Neutral Agree Strongly Agree

Comments *(please list any specific expenses of concern, e.g. medical bills, transportation, lodging, rent/mortgage, utilities, etc.)* _____

- **I have a good emotional support "system" to help me get through the stresses and strains of the patient's illness.**

Strongly Disagree Disagree Neutral Agree Strongly Agree

Comments _____

Please check all that apply:

- **I'd like to learn more about...**

- The diagnosis
- Communicating with the health care team
- Emotional aspects of coping w/serious illness
- Treatment options facing
- Insurance/benefits issues
- Opportunities to interact with peers similar circumstances
- Side effects
- Financial assistance

Please use the space below for any additional comments or concerns:

