

Referral Form to Herald Cancer Care Network

(For Chinese Cancer Patients Only)

Please fax to: 408-986-8581

Please use this form to refer your patient/client to the Herald Cancer Care Network (HCCN), when s/he needs the services HCCN offers and allows you to release the contact information. Please fill out the form and fax it to HCCN. You may also ask your patient/client to visit the HCCN website at <http://cancer.heraldcare.org> or contact HCCN directly at (408)986-8584.

All information will remain confidential. This is not a solicitation.
All Herald Cancer Care Network services are **FREE** of charge.

My client is interested in:

- Cancer information in Chinese
- Teleconference cancer educational seminars in Mandarin
- Emotional support through telephone care
- Support groups meetings
- One-on-one home visitation through a trained volunteer

*** Required fields**

* Referred by:	* Phone: ()
* Patient Name:	Chinese Name:
* Daytime Phone: ()	* Primary Language:
Address:	City: State: Zip:
Type of Cancer:	Sex:
Contact Person/Relationship: (if other than patient)	Phone: ()
Patient Signature:	Date:
Comments:	

Herald Cancer Care Network
3131 Bowers Ave., Santa Clara, CA 95054
Telephone: (408)986-8584 x 101, Fax: (408)986-8581

The information contained in this facsimile message is confidential. It is intended for the use of the Herald Cancer Care Network. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this telecopy is strictly prohibited. Please fax it to the Herald Cancer Care Network at the above number. Thank you for your cooperation.

「角聲癌症關懷」轉介表格

(服務只供華裔癌症患者和家屬)

請傳真至：408-986-8581

當華裔癌症患者和家屬需要角聲癌症關懷所提供的下列服務，並允許您提供他/她的聯絡資料時，請使用此表格轉介服務對象到角聲癌症關懷 (HCCN)。請填寫此表格後傳真至角聲癌症關懷 408-986-8581。你也可以請華裔癌症患者和家屬瀏覽角聲癌症關懷網址 <http://cancer.heraldcares.org> 或直接來電 (408) 986-8584 聯絡角聲癌症關懷。

角聲癌症關懷對所有的資料都會保密。
所有角聲癌症關懷的服務都是免費。

我的病人對以下服務感興趣：

- 中文癌症資訊
- 國語電話會議式癌症教育講座
- 電話關懷
- 癌友及家屬互助會
- 居家探訪

* 必須填寫

* 轉介機構或轉介人：

* 電話：()

* 病人英文姓名：

中文姓名：

* 聯絡電話：()

* 慣用語言：

地址：

城市： 州： 郵區編號：

癌症類型：

性別：

連絡人/關係：

(如果不是病人本身)

電話：()

病人簽名：

日期：

附註：

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