Please have your physician’s office complete this form and return to Wellness Place.

Patient’s Date of Birth:

Patient’s Full Name:

Patient’s Preferred Name:

Pronouns:

Patient’s Email:

Patient's Phone Number:

Patient’s Mailing Address:

Patients Primary Language:

Oncologist Name:

Primary Care Number:

Primary Care Location:

Cancer Diagnosis:

Course of Treatment:

How Can We help?

- ☐ **Add to Mail/Email List**
- ☐ **Adult with Cancer Comfort Care Kit**
- ☐ **Gas Card**
- ☐ **Head Covering**
- ☐ **Mindfulness-Based Stress Reduction Classes**
- ☐ **Port Pillow**
- ☐ **Protein Shake: Chocolate (1.65 lbs) Box**
- ☐ **Protein Shake: Chocolate Sample**
- ☐ **Protein Shake: Vanilla (1.65 lbs) Box**
- ☐ **Protein Shake: Vanilla Sample**
- ☐ **Protein Shake: Unflavored (1.65 lbs) Box**
- ☐ **Protein Shake: Unflavored Sample**
- ☐ **Protein Shake: Berry (1.65 lbs) Box**
- ☐ **Quilt/Blanket**
- ☐ **Support Group**
- ☐ **Wig**
- ☐ **Unsure**
- ☐ **Other**

____

Printed name of authorized signer at Oncology office

____

Signature of authorized signer

____

Date

Please note:

An authorization form must be completed annually by your physician's office. Please contact us for information on our benefits and services.

WELLNESS PLACE

Please visit our website for hours of operation

www.CancerSupportNCW.org

509-888-9933

610 N Mission St Suite #202

(Located on the second floor of the professional building)