



The Sharon L. Bassett Foundation helps women and men in Indiana and Illinois who are living with breast cancer. To be considered for services, we would like to gather a small amount of information about you. This information will not be used for any purpose other than to offer assistance through our foundation.

Referred by: MD _____ RN _____ SW _____

Demographics:

Name: _____

Address: _____

Phones: H:() _____ W:() _____

C:() _____

Email address: _____

Insurance: Yes _____ No _____ Employed: Yes _____ No _____

Health:

Diagnosis: _____ Date of Diagnosis: _____

Stage of Diagnosis: _____

Are you currently in treatment: Yes _____ No _____

Surgery: _____ Chemo _____ Radiation _____

Do you have any other health problems? _____

Personal Situation:

Married _____ Divorced _____ Single _____ Widowed _____

Children: How many and ages:

Whom do you live with?

Whom do you ask for help when you don't feel well?

How far/how often do you travel for doctor/treatment appts.?

Who comes with you to your appts. and/or treatments?

What do you do for enjoyment?

What are your hobbies or special interest?

Needs:

Please share with us your worries or concerns.

What things have become difficult for you since your diagnosis?

How can we help you? (Day to day living, companionship, information or clarification about breast cancer or survivorship, expenses related to treatment, etc. These are only examples. Please share your special needs or requests.)

How can we help your family?

Is there anything you would like us to know about you or your family that has not already been addressed?

I consent to the Sharon L. Bassett Foundation to contact my supervising physician, Dr. _____, to verify my diagnosis and treatment therapy. I will not hold the Sharon L. Bassett Foundation liable for any damages or claims that may result in provided services or goods. I give the Sharon L. Bassett Foundation permission to use my story/photo in newsletters and media coverage to inspire other survivors.

Signature: _____

Date: _____

To be completed by Health care provider:

Referral from: _____

Phone: _____ **e-mail:** _____

I have referred (breast cancer survivor) _____

**To the Sharon L. Bassett Foundation
for the following reasons:** _____

Signature: _____ **Date:** _____

Return form to Sharon L. Bassett Foundation
1555 West Oak Street, Suite 100
Zionsville, IN 46077
317.632.1252
317.733.1545 Fax