update 8/27/18

Cancer Support Community - Greater Lehigh Valley
ANNUAL VISITOR INFORMATION FORM

Cancer Support Community (CSC) gathers information about every program participant to help us better understand the community we serve so that we can provide the highest quality of programs possible. Also, since CSC is a non-profit organization that offers high quality services at **no cost** to participants, we rely solely on donations to underwrite our programs. Therefore, we need the following information to help us secure funding. All personal information will be kept **confidential**. The information provided to funders will be limited to combined demographic data of **all** participants with no individually identifying information. Your answers to these questions will, in no way, affect your ability to access **all services** offered by CSC at no cost.

PLEASE PRINT CLEARLY. *THANK YOU!*

Date: _____ **Location:** ❑ CSC Marcon Boulevard ❑ Other: _____

If you are a new member, the program you're attending today: _____

Last Name: _____ **First Name**: _____ **Middle Initial:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

County: _____

Contact Phone: (home) _____ (work)_____ (cell)_____

Contact Email: _____

I am a: ❑ Cancer Survivor ❑ Support Person ❑ Healthcare Professional ❑ Volunteer ❑ Other _____

Do you have children between the ages of 5 and 17? ❑ Yes ❑ No If yes, what age(s): _____

Number in Household _____

Emergency Contact: _____ **Relationship**: _____

Phone: (home) _____ (work) _____ (cell) _____

How would you like our bi-monthly calendar sent to you? ❑ By email ***(preferred)*** ❑ By mail

Please complete the following demographic questions ***about yourself***

Sex: ❑ M ❑ F **Date of Birth:** _____ **Are you a Veteran:** ❑ Yes ❑ No

Marital Status: ❑ Single ❑ Living with Partner ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Ethnicity:❑ Caucasian❑ African American❑ White Hispanic❑ Black Hispanic❑ Asian ❑Biracial ❑American/Pacific Islander❑ American Indian/Alaska Native/First Nations❑ Other _____

Type of Insurance: ❑ Uninsured ❑ Medicare Only ❑ Medicare + Private ❑ Medicaid ❑ Private Insurance

Employment Status:

❑ Employed full or part-time ❑ On medical leave ❑ Disabled ❑ Not employed ❑ Retired

Employer: _____ Occupation: _____

Annual Family Income (optional):

❑ Under $25,000 ❑ $25,000-49,999 ❑ $50,000-74,999 ❑ $75,000-$99,999 ❑ $100,000+

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IF YOU ARE A CANCER SURVIVOR, *please complete the following* ***about yourself***

Cancer Diagnosis: _____ **Date Diagnosed:** _____

Stage of Disease: ❑ Newly diagnosed ❑ In active treatment ❑ In remission
❑ Recurrent ❑ Metastatic disease ❑ Not sure

Oncologist's Name: _____

Hospital: _____ **City/State:** _____

IF YOU ARE A SUPPORT PERSON OR A CAREGIVER, *please complete the following* ***about the survivor***

What is the name of the person that you are here to support? _____

I am this person's_____

What is your loved one's diagnosis? _____Date Diagnosed:_____

Stage of Disease: ❑ Newly diagnosed ❑ In active treatment ❑ In remission
❑ Recurrent / metastatic disease ❑ Not sure

Oncologist's Name: _____

Hospital: _____ **City/Sate:** _____

How did you hear about the Cancer Support Community?

❑ Doctor ❑ Nurse ❑ Social Worker ❑ Friend / Family ❑ Newspaper ❑ TV / Radio
❑ Internet ❑ CSC Staff / Volunteer ❑ Health Fair/Community Event ❑ Other _____

If you were referred by a healthcare professional, please complete the following:

Name of person who referred you: _____

Affiliated Hospital or Office: _____ **City/State:** _____

Can we send a *Thank You* note to the person who referred you? ❑ **Yes** ❑ No

Please feel free to sign up for our current programs on the signup sheets in the common area.

A clinical facilitator from CSC will contact you by phone as a follow up courtesy. If you do not wish to be contacted please check this box: ❑

I understand that if I participate in any programs sponsored by **Cancer Support Community Greater Lehigh Valley**, I am responsible for ascertaining my physical and emotional ability to participate. I waive any claims that I may have against **Cancer Support Community Greater Lehigh Valley** by virtue of participating in this program and any other programs offered to me in the future.

Your signature _____

FOR OFFICE USE ONLY- Please initial once each step is completed

_____ **GNOSIS** _____ **MAILING LIST** _____ **FOLLOW-UP PHONE CALL**

_____ **MEMBER ID CARD** _____ **CANCER SUPPORT SOURCE**