240 Meeting House Lane, Stony Brook Southampton Hospital, Southampton, NY 11968

This form must be completely filled out and include a doctor's note of diagnosis in order to be eligible for services. All information submitted is confidential.

COALITION FOR WOMEN'S CANCERS
AT STONY BROOK SOUTHAMPTON HOSPITAL
INTAKE FORM

- NAME: _____ DATE: _____
- DATE OF BIRTH: _____ AGE: _____
- MAILING ADDRESS: _____ TOWN: _____
- ZIP: _____ SOCIAL SECURITY # _____
- COUNTRY OF CITICENSHIP: _____
- PHONE: _____ CELL: _____ EMAIL: _____

  ☐ Please include my email in your mailing list. ☐ Please keep my email confidential.

- Would you like to be part of our private peer to peer support group on FaceBook? If yes, What is your FaceBook contact information?

  _____

- RACE: _____ ETHNICITY: _____
- LEVEL OF EDUCATION: _____ SPOUCE/PARTNER NAME; _____
- OTHER HOUSEHOLD MEMBERS AND AGES: _____
- OCCUPATION: _____ EMPLOYMENT STATUS: _____
- PAST COLLECTIVE HOUSEHOLD INCOME: _____
- PRESENT COLLECTIVE HOUSEHOLD INCOME: _____

- CURRENT PATIENT INCOME: _____ PAST PATIENT INCOME: _____
- DIAGNOSIS: TYPE OF BREAST CANCER: _____
- DATE: _____ STAGE: _____
- HOSPITAL: _____ SURGEON: _____ TYPE:_____
- TYPE OF TREATMENT: _____
- ANTICIPATED DURATION OF TREATMENT: _____
- ONCOLOGIST: _____ RADIATION ONCOLOGIST: _____
- FAMILY HISTORY OF BREAST CANCER: ☐ YES ☐ NO
- INSURANCE CARRIER: _____
- MEDICAID/MEDICARE: ☐ YES ☐ NO
- HOW DID YOU HEAR ABOUT US? _____

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