REFERRAL FORM

The Comadre a Comadre Program's mission is to empower the lives of Hispanic/Latina women and their loved ones through advocacy, support, education, navigation, resources, and research about breast health and breast cancer.

REFERRAL SOURCE

Name of person making referral (Please Print):_____

I am a: ☐Physician ☐Physician's Assistant ☐Nurse ☐Case Manager ☐ Promotora

Cancer Center/Clinic/Organization: _____

Phone Number: _____ Fax Number:_____

Date of referral:_____

REASON FOR REFERRAL

Check Box:☐ Screening Mammogram- Barriers ☐ Diagnostic Procedures Needed-Barriers

☐ Breast Cancer Diagnosed Support/CA Services Needed

☐Other_____

PATIENT INFORMATION

Name (Please Print):_____

Address: _____

Contact Phone Numbers: Home_____ Cell_____

Family or friend's number (IF patient has no phone#):_____

Name of person & relationship to patient_____

Patient speaks: _____Spanish ____English ____Both

HOW PATIENT WAS INFORMED ABOUT THE PROGRAM (CIRCLE ONE)

1) An explanation and/or a brochure about the **FREE** *Comadre A Comadre Program* have been given to me. I give my permission for the *Comadre A Comadre* Program to have my name, address and phone number(s) and to contact me about participating in the program.

Signature:_____ Date:_____

OR

2) Verbal permission obtained by patient from:

Signature:_____ Date:_____

Thank you for completing this referral. Please call the Comadre Program at # 277-2398 to confirm fax.

Fax this referral form directly to our own private fax #277-2352

Revised 7/12/16