Hawaii Children's Cancer Foundation
PATIENT/FAMILY INFORMATION SHEET

PLEASE PRINT

PARENTS [ ] GUARDIANS [ ] (Please check one)

Mother:

Last ______________________________ First ______________________________

Mailing Address ____

City ______________________________ Zip ______________ Island ______________

Home Phone ______________________________ Business Phone ______________________________

Father:

Last ______________________________ First ______________________________

Mailing Address ____

City ______________________________ Zip ______________ Island ______________

Home Phone ______________________________ Business Phone ______________________________

CHILDREN IN HOUSEHOLD

	Last Name	First	Sex	Date of Birth
* (Patient)				

(If you need more space, please continue on back)

Child's (*Patient) Diagnosis ____

Treating Physician's Name ____

Treating Facility ____

Date Diagnosed Mo.__________ Year __________

[ ] Currently in Treatment [ ] Treatment Completed [ ] Treatment Completed > 5 years

I am interested in the following:

[ ] Financial/Travel Assistance
[ ] Parent to Parent Support
[ ] Children's/Siblings Groups
[ ] Getting support/special help for child to succeed in school
[ ] Information on child's diagnosis
[ ] Long term follow-up care
[ ] Candlelighters (national childhood cancer organization)
[ ] Volunteering for HCCF
[ ] Other ____

How did you hear about HCCF?

[ ] Other parents/family   [ ] Physician   [ ] Nursing Staff

[ ] Social Worker   [ ] HCCF Newsletter   [ ] HCCF Website

[ ] Other ____

You will automatically be enrolled as an HCCF member (there is no fee)
and added to our mailing list for all activities & events.

Signature ______________________________________ Date______________

TO REQUEST SERVICES OR INFORMATION, PLEASE CALL:
OAHU 808-528-5161
NEIGHBOR ISLANDS TOLL-FREE 1-866-443-HCCF

Please mail this form to:
Hawaii Children's Cancer Foundation
1814 Liliha St.
Honolulu, HI 96817

FOR OFFICE USE

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