Child Patient Intake Form

Please fill out and email to forms@rockcancercare.org
For questions or for more information call 1 888-251-0620 or visit rockcancercare.org
For children 0 to 18years old and their parents

Today's Date: _____

Name of person completing form: _____

Who referred you or how did you find out about us? _____

Have you received services from us in the past? _____

Please check one

- Are you seeking services for your child?
  YES NO
- Are you a family member seeking help for a child in your family that has cancer?
  YES NO
- I am a health professional

Household Information

Name of Parents:_____
Address: _____
Phone Number: Mom_____Dad_____
Is it ok to leave a message?_____
Email:_____
Names of adults living in the home besides Parents?_____
Names & ages of
Siblings:_____

Child Patient Information

Name of Patient: _____
Gender: _____
Birth Date: _____
Age: _____
Primary Language: _____
Address: _____
Type of Cancer: _____
Date of Diagnosis: _____
Location of Cancer Treatment: _____
Name of Social Worker _____
Name of Doctor: _____

Child Profile Information

What do you enjoy most about your child?
_____.

How would you describe your child (personality characteristics?
_____.

Is there anything else in your child's experience you would like to tell us so we can better meet your child's needs? _____

What are the foods your child likes best? Desserts and meals
_____
Least? _____

Does your child have any allergies? _____

What would you like most for your child to experience with us? Our desire is to help anyway we can.
_____

Does your child use a walker, crutches, cane, or wheelchair on a regular basis? YES NO

Do you currently have family helping you with your everyday needs? YES NO

Is your child in active treatment? YES NO

Do you have Pets? YES NO If yes what kind?_____

What's your child's favorite colors?_____

If yes, please indicate type of treatment:

- Bone Marrow Transplant
- Chemotherapy
- Clinical Trial
- Holistic/Alternative
- Palliative Care
- Radiation
- Stem Cell Transplant
- Surgery
- Other:

If no, is post treatment follow-up needed? YES NO
If yes, what is the type of follow-up needed? _____

Health History (circle all that apply)

AIDS
Allergies
Anemia
Anxiety
Asthma
Chemical Sensitivities
Chronic Fatigue
Diabetes
Dizziness
Environmental Sensitivities
Eyesight-Needs glasses
Fatigue
Headaches
Hearing Problems

Hepatitis A
Hepatitis B
Hepatitis C
High Blood Pressure

HIV
Injuries
Low Blood Pressure
Memory Loss
Seizures

Shortness of Breath
Stiffness
Swelling
Other:
_____

Does your child have any medication allergies? YES NO
If yes please list them:

*What are your religious beliefs? _____
*Are you open to being prayed for?_____

**Patient does not have to answer this question, it is helpful for us to know their religious beliefs and how they feel about being prayed for so we can respect their wishes.*

Emergency Contact

Name: _____
Phone: _____
Cell Phone: _____
Address: _____
Relationship to Patient: _____

Services We Offer Circle all that apply

- Arts & Crafts in home (family must be vaccinated)
- Education and Awareness
- Grocery Shopping (using your funds)
- Hospital Visitation
- House Cleaning with outside company when grant available
- Free Meal Delivery for parents and children
- Free Groceries and delivery
- Prescription & Financial Assistance when available
- Support Groups for Parent
- Prayer & Support for Parent

For financial Assistance Only

For those parents seeking financial assistance such as prescription assistance, free groceries. free meals, free housecleaning and other types of financial aid

Please Include:
-Medical Diagnosis Form to be filled out by a physician. This is the last page of this application.

Please note all information provided to Rock Cancer C.A.R.E Inc. in support of this application shall be considered true and accurate.

I confirm that the above information is complete and true, to the best of my knowledge.

I authorize Rock Cancer C.A.R.E. to use the information for the purpose of determining how best to serve the patient listed above based on his/her needs. I understand that I may revoke this authorization at any time.

I hereby release Rock Cancer C.A.R.E. from any/all legal liability that may arise from the use of this information.

I understand that I have the right to receive a copy of this authorization upon my request. (Civil Code Section 56.11)

Parent Signature _____Date_____

RELEASE AND WAIVER OF LIABILITY AND INDEMNITY AGREEMENT

RELEASE AND WAIVER OF LIABILITY

1. IN CONSIDERATION of being permitted to utilize the services and programs of Rock Cancer C.A.R.E., the undersigned, for himself or herself and such participating children and any personal representatives, heirs, and next of kin, hereby RELEASES, WAIVES, DISCHARGES AND COVENANTS NOT TO SUE Rock Cancer C.A.R.E., Inc., their directors, officers, employees, and agents (hereinafter referred to as "releases") from all liability to the undersigned, his or her personal representatives, assigns, heirs, next of kin for any loss or damage, and any claim or demands therefore on account of injury to the person or property or resulting in death of the undersigned or such children, whether caused by negligence of the releasees or otherwise while the undersigned is participating in any program affiliated with or receiving services provided by Rock Cancer C.A.R.E. Inc. Any dispute between the parties relating to this Agreement or its interpretation will be resolved by binding Arbitration, in accordance with the commercial arbitration rules of the American Arbitration Association in California. The arbitrator(s) will be limited to awarding compensatory damages and will have no authority to award punitive, exemplary or similar type damages. I UNDERSTAND THAT I AM GIVING UP THE RIGHT TO A JURY COURT TRIAL.

2. THE UNDERSIGNED HEREBY ASSUMES FULL RESPONSIBILITY FOR AND RISK OF BODILY INJURY, DEATH OR PROPERTY DAMAGE due to negligence of releasee or otherwise while utilizing the services of Rock Cancer C.A.R.E. or participating in any program affiliated with Rock Cancer C.A.R.E. Inc.

3. THE UNDERSIGNED further expressly agrees that the forgoing RELEASE, WAIVER and INDEMNITY AGREEMENT is intended to be as broad and inclusive as is permitted by the law of the State of California and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

INDEMNITY

1. THE UNDERSIGNED HEREBY AGREES TO INDEMNIFY AND SAVE AND HOLD HARMLESS the releases and each of them from any loss, liability, damage or cost they may incur due to the undersigned, participating children and any personal representatives, heirs and next of kin's, use of Rock Cancer C.A.R.E. services or participating in any program affiliated with Rock Cancer C.A.R.E. whether caused by the negligence of the releasees or otherwise.

THE UNDERSIGNED HAS RED AND VOLUNTARILY SIGNS THE RELEASE AND WAIVER OF LIABILITY AND INDEMNITY, and further agrees that no oral representations, statements of inducement apart from the foregoing written agreement have been made.

Parent Signature_____ Date_____

TO BE COMPLETED BY PHYSICIAN, NURSE, OR SOCIAL WORKER ONLY!!!

All information is mandatory. Physicians will be contacted

MEDICAL DIAGNOSIS FORM

Date of Diagnosis: _____ Primary Cancer: _____

☐ Stage of Cancer: _____ New Diagnosis Recurrence

☐ In Active Treatment? YES NO

If yes, please indicate type of Treatment (circle all that apply):

☐ Chemotherapy Bone Marrow/Stem Cell Transplant

☐ Clinical Trial

☐ Radiation Surgery

☐ Bone Marrow/Stem Cell Transplant

☐ Palliative Care Complementary/Alternative/Holistic

☐ If No, Is post treatment follow-up needed? YES NO

Type of Follow-up: _____

What is the expected length of treatment? _____

What is the estimated recovery time? _____

Physician's Name: _____ Hospital/Clinic: _____

Address: _____ City/State/Zip: _____

Phone: ( ) _____ Fax: ( ) _____

Print Name/Title of Person completing this Form: _____

Thank you. A member of the Rock Cancer C.A.R.E. staff will review this information and contact the patient. All information is strictly confidential and is intended for RCC use only except as noted in the applicant acknowledgment section.