FAMILY INFORMATION

Patient Name:	Date of Birth:
Parents Name:	
Email Address:	
Address:	
City:	Province:
Postal Code:	Telephone:
Referred By:	

HEALTH INFORMATION

Diagnosis:	Date of Diagnosis:
Estimated Treatment Time – Plan:	
Oncologist:	Hospital/Facility:
Primary Nurse or Social Worker (if applicable):	

REQUEST FOR FUNDING

Prescription Drugs:
Equipment Rentals - Purchase:
Transportation & Meals (Separate Travel Application Required)
Wig:
Other:
Do you have extended health benefits to cover some of these expenses related to your treatment? YES NO
Are you receiving services from the Community? YES NO
How has the diagnosis and/or treatment of your cancer impacted your ability to pay for these expenses?

VERIFICATION

I (Parent/Guardian) verify this information to be true: _____	_____
Signature	Date
Believe in the Gold use: _____	_____
Signature	Date