ONE-ON-ONE SUPPORT MATCH REQUEST

CANCER HOPE NETWORK

CONTACT INFORMATION	REFERED BY (HEALTH CARE PROFESSIONAL)
Match request is for: patient / family / other	Name:
Relationship to patient:	Position:
Name:	Organization:
Phone #:	Phone #:
Email:	Email:
City, State:	Gender: Age:
Best times/days to be reached:	

CANCER INFORMATION	
Cancer type:	Date of Diagnosis:
Stage:	
Any additional information about diagnosis/treatment:	

HOW CAN WE BEST HELP?/ CONCERNS

PERMISSION TO CONTACT

I, _____, request for Cancer Hope Network staff to contact me directly to assist in matching me with a support volunteer survivor who has been through a similar cancer experience. I am the person who would like to be matched and understand that support volunteers can only contact the individual(s) who have given their consent. I understand that Cancer Hope Network's services are provided by trained peer cancer survivors who are not mental health professionals. I also understand that their staff and volunteers are not medical professionals and cannot provide medical advice.

By signing this form, I verify that this request was made by me and that I agree with the statements above.

Signature: _____ **Date:** _____

Cancer Hope Network will review this information and respond to your request within the next business day. Our office hours are Mon-Fri 9am-5:30pm EST.

P: 877- 467- 3638 **F: (908) 879– 6518** **info@cancerhopenetwork.org**