LISA'S PINK PETALS OF HOPE
106 W. ROBERTSON STREET
BRANDON, FL 33511
(813) 661-7465
pinkpetalsofhope@gmail.com

MAMMOGRAM APPLICATION

LPPOH uses the following information to help determine eligibility. All information is kept confidential, unless otherwise stated.

Date: _____

Who referred you to us today? _____

Name: _____

SSN: _____-_____-_____ DOB: _____/_____/_____ Age: _____

Address: _____ City: _____ State: _____

Home # _____/_____ Cell # _____/_____

Email address: _____

Are you currently employed? Y/N

If yes, who is your employer? _____

Do you have insurance? Y/N Insurance Name/ID Number: _____

Referring Physician: _____

Physician Address/Tele: _____

Note: MUST have a prescription for a mammogram to qualify for this service, do you? Y/N

Are you having symptoms? Y/N

Describe symptom: _____

Do you have a Family history of breast cancer? Y/N Related family member _____

Age @ diagnosis? _____

Household Income: _____ (wk/mo/yr)

Other $ _____ (include job income, unemployment, SSI, child support, alimony, etc.)

Fax completed form to (813) 681-7465

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Service Eligibility & Release of Information Form We need these documents- please send LEGIBLE copies with your application:

- ☐ Copy of Photo ID
- ☐ Copy of W-2 or last year's tax return
- ☐ Last 2 pay stubs (if you don't have W-2 or tax return)
- ☐ Prescription or referral from Physician

Patient's Statement of Understanding I have read and understand the above and declare the information furnished by me is true and complete to the best of my knowledge. I consent to the exchange of information between Lisa's Pink Petals of Hope (LPPOH) and other community agencies to provide needed services.

If I am approved for services, I understand that any appointment changes, cancellations, or reschedules must be done through LPPOH or I may be billed by the service provider.

I hereby authorize LPPOH to disclose appropriate medical information regarding my care to my referring agency, (agency name) _____. I authorize LPPOH to give my medical results to _____.

_____ _____

Signature of Patient / Responsible Party Date

Internal Office:

LPPOH Intake Staff: _____ Date: _____

Application received by: FAX/MAIL/EMAIL/PHONE/WALK-IN

Eligibility: Yes or No If yes, applicant contact date: _____

Scheduled mammogram appointment date: _____

Add'l Comments/Actions: _____

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