LYMPHOMA
RESEARCH • FOUNDATION

PHYSICIAN REFERRAL FORM

Dear Physician:

Your patient, _____. is applying to the Lymphoma Research Foundation's COVID-19 Financial Assistance Program. The goal of this program is to assist patients with quality of life costs that are not covered by insurance. Please complete the information below. It will be a part of the patient's grant application. Thank you for your assistance.

Diagnosis (please circle): Hodgkin Lymphoma or Non-Hodgkin Lymphoma

Cell Type (please circle): B-cell or T-cell **Grade** (please circle): Low Intermediate High

Please specify subtype_____Date of initial diagnosis _____

Current Treatment _____

Physician Signature_____Date_____

Name (please print) _____Title_____

Institution/Affiliation _____Telephone_____

ADDITIONAL INFORMATION SECTION (OPTIONAL: THE FOLLOWING SECTION IS NOT REQUIRED)
Dear Healthcare Professional or Social Worker:

Your patient _____ is applying for a financial assistance from the Lymphoma Research Foundation and feels that your insight would be beneficial. The goal of this grant is to assist patients with quality of life costs that are not covered by insurance. Please use the following lines to share with us any information you feel is important about this patient and his/her need for this grant. Thank you for your assistance.

_____

Signature of Healthcare Professional or Social Worker_____Telephone_____
_____Email_____

Name (please print) _____Title_____Institution & Address_____