

## PATIENT REFERRAL APPLICATION

Please complete ALL areas of this form (*Note: There are two pages to complete*).

DATE OF APPLICATION: ____ / ____ / _____			
<b>1. REFERRING SPECIALIST</b>			
Provider Number:		Position held:	
First Name:		Last Name:	
Hospital:			
Business Phone:		Mobile:	
Email:			

<b>2. PATIENT DETAILS</b>			
First Name:		Middle Name:	
Last Name:			
Date of Birth:		Medicare No:	
Street Address:			
Suburb:		State:	
		Post code:	
Phone (Home):		Mobile:	
Email:			

<b>3. PATIENT CONDITION</b>			
Condition:		Stage:	
		Date of Diagnosis:	
Prior Treatment 1 <sup>st</sup> Line:		Prior Treatment 2 <sup>nd</sup> Line:	
Post Treatment Results 1 <sup>st</sup> Line:		Post Treatment Results 2 <sup>nd</sup> Line:	
New Medication Required:		Commencing:	

Patient History/Comments:
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[See over for NEXT OF KIN details](#)

4. NEXT OF KIN			
First Name:		Last Name:	
Phone (Home):		Mobile:	
Email:			
Relationship to Patient:			

The John Logan Foundation (JLF) financially supports Australians living with cancer. We assist people by helping to fund treatments and procedures prescribed by a Medical Oncologist or Surgeon that are not available on the Pharmaceutical Benefit Scheme (PBS). To refer a patient, please complete the Patient Referral Application form and email to: [katherine@johnloganfoundation.com.au](mailto:katherine@johnloganfoundation.com.au) and CC [admin@johnloganfoundation.com.au](mailto:admin@johnloganfoundation.com.au)

This application will be considered by the JLF appointed Medical Advisory Panel. The assessment process will take no longer than 10 (ten) business days so treatment can commence as soon as possible. Following receipt of this Patient Referral Application form, a JLF representative will contact the patient to discuss their Financial Assessment.

Each application is processed individually. All patient information supplied will remain private and confidential.

Payments for treatment are made directly to the hospital or pharmacy provider as required.