**CANCER SOCIETY** **NELSON TASMAN**

**COUNSELLING REFERRAL**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Name: |  | Cancer Diagnosis & Date: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Is this application for *(please tick):* | Patient | Spouse/Partner | Family member |

**Contact details**

|  |  |
| --- | --- |
| Applicant Name: |  |

|  |  |
| --- | --- |
| Address: |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Postcode: | |  | | Email: |  | | |
| Phone: | Home | |  | | | Mobile |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Ethnicity: | Māori | NZ Pakeha/Caucasian | Other (state) |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Date of Birth: |  | Gender: |  |

|  |  |  |
| --- | --- | --- |
| Name of Spouse/Partner/Family member: |  | Lives Alone |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Employed | Sick leave | Retired | Other Benefit: |  |

|  |  |
| --- | --- |
| Name and ages of any dependent children: |  |

**RELEVANT HEALTH INFORMATION:**

|  |
| --- |
|  |

**What assistance is requested?** *(Specific details)*

|  |
| --- |
|  |

**Any other supporting information that will assist?**

|  |
| --- |
|  |

**Name and position of person submitting this application on behalf of applicant:**

*(Must be a health professional / social worker / Cancer Society staff member)*

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Position: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Telephone: |  | Email: |  |

**Please confirm the proposed recipient of this grant is aware of this application and that all information is kept securely in accordance with the Privacy Act 1993:  YES**

**Note:** Anyone accepting a counselling grant is registered as a Cancer Society member

***Please send completed form to Cancer Society Nelson Tasman:***

Support Coordinator: [cyndy@cancernelson.org.nz](mailto:cyndy@cancernelson.org.nz) *or* Manager: [michelle.hunt@cancernelson.org.nz](mailto:michelle.hunt@cancernelson.org.nz)

Ph 03 539 1137

**Cancer Society office use only**

|  |  |  |
| --- | --- | --- |
| This grant:  Approved/ Declined | Signed: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Date: |  | Amount: |  |

Payment arrangement:  bill payment (attach bill to form) / direct to client (provide bank account details)

|  |
| --- |
| Please invoice to: Cancer Society Nelson Attn Manager PO Box 335 Nelson 7040 c/- [cyndy@cancernelson.org.nz](mailto:cyndy@cancernelson.org.nz) |