American Cancer Society Hope Lodge®

Hope Lodge Request Form

125 S. Huntington Ave., Boston MA 02130
Contact: 617-396-5500

Please complete (print) ALL fields and fax form to 617-278-1585 or email form to HopeLodgeBostonMA.org

To view our privacy policy, please visit cancer.org and click on the 'Privacy Policy'" link at the bottom of the page or call us at 1-800-227-2345.

Lodging Request

Requested Arrival Date:	Anticipated Departure Date:
Treatment Facility:	
Additional Information/Comments:	

Patient Information

Patient Name:		
Home Street Address:		
City:	State:	Zip:
Primary Phone: ☐ Home ☐ Cell	Email:	
Date of Birth:	Primary Language: ☐ English ☐ Spanish ☐ Other:	
Preferred Pronoun: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Another Pronoun		
Diagnosis Date:	Type of Cancer	
Type of Cancer Treatment:	Treatments per week:	
Caregiver Name:	Phone:	Relation to Patient:
Emergency Contact:	Phone:	Relation to Patient:

Eligibility Questions

	Patient	Caregiver
1. Does the guest need translation services?	☐ Yes ☐ No	☐ Yes ☐ No
2. Does the guest require a service animal for a disability?	☐ Yes ☐ No	☐ Yes ☐ No
3. Does the guest need a wheelchair-accessible room?	☐ Yes ☐ No	☐ Yes ☐ No
4. Does the guest have any infectious diseases or infectious-disease symptoms?	☐ Yes ☐ No	☐ Yes ☐ No
5. Has the guest ever been convicted of a crime of violence, crime of domestic violence, crime against a child, crime of theft, or a crime involving illegal drugs?	☐ Yes ☐ No	☐ Yes ☐ No
6. Does the guest have a civil protection order against them?	☐ Yes ☐ No	☐ Yes ☐ No
7. Is the guest on probation or parole?	☐ Yes ☐ No	☐ Yes ☐ No
8. Has the guest been required to register on the State or National Sex Offender Registry?	☐ Yes ☐ No	☐ Yes ☐ No

Referral Information

As the referring source, I have explained the American Cancer Society (ACS) guidelines and affirm that, to the best of my knowledge, the patient listed above does not have any communicable or infectious diseases or infectious-disease symptoms. I have reviewed the eligibility requirements with the patient, and I affirm that he/she meets all of these. I explained the ACS Hope Lodge services to the patient, and I have obtained express authorization to disclose this information to ACS for purposes of applicable follow up and referral to the Hope Lodge facility and future engagement with ACS.

Treating Physician:	Referral Contact:	
Department:	Contact Phone:	Contact Email:
Treating physician or referring contact's signature:		Date:

Patient Signature

To be signed by Patient upon arrival at the Hope Lodge. If currently inpatient, mark **IP** until patient arrival.

I have reviewed and confirmed the accuracy of the data provided in the Patient Information and Eligibility sections on this form.

Patient signature:	Date: