Thomas & McMahan
CANCER FOUNDATION

The mission of the foundation is to enhance the quality of life for New Orleans area cancer patients and their families throughout their cancer experience. Our customized patient programs and services allow patients to regain control of their lives during difficult times and are meant to help ease stressors during treatment and into remission.

Of the following services we offer, please check off the options you need assistance with:

☐ Cab rides	☐ Meal delivery	☐ Yoga- Covington	☐ Yoga- New Orleans
☐ Cost of gas	☐ In-home caregiver services	☐ Yoga- Slidell	☐ Yoga- Metairie

Name: _____ Date of Birth: _____

Street Address: _____ City, State, Zip Code: _____

_____ Parish: _____

Phone #: _____ Phone #: _____

Email : _____

Circle the best time you can be reached:

Morning (8-11)	Afternoon (12-3)	Evening (4-7)

The following information is requested to best serve your needs and interests:

Please check the appropriate choice for each of the following:

Sex:	Marital Status:	Race/Ethnicity:	
☐ Male	☐ Married	☐ African American	☐ Hispanic/Latino
☐ Female	☐ Single	☐ Asian	☐ Native American
	☐ Cohabitating partnership	☐ Caucasian	☐ Other: _____

Name of Oncologist: _____ Hospital/Clinic: _____

Type of Cancer: _____ Stage: _____

Status:
- ☐ Newly diagnosed
- ☐ Recurrence
- ☐ Remission

Are you currently receiving treatment? Yes / No

If not currently being treated, when was the last treatment? _____

Referral Source:
- ☐ Name of physician/nurse/ medical staff: _____
- ☐ Flyers/posters
- ☐ Facebook
- ☐ Website
- ☐ Other: _____

Signature: _____ Date: _____

Release and Agreement

Name of Patient _____ DOB: _____

I am eighteen years of age or older and have voluntarily applied to take part in various activities offered through the Thomas/McMahan Cancer Foundation. I understand that some activities may expose me to hazards or risks that could result in my injury and I understand and appreciate the nature of such risks and hazards.

I wish to take part in these activities, and I accept the risks and hazards that may result from such participation. I hereby release the Foundation, its officers, employees, and agents from any liability to me, my estate, heirs, and assigns for any and all claims and causes of action for loss of or damage to my property and for any injury to my person that may result from or occur during my participation in any Foundation's activity, program or service.

I understand that no health insurance is to be provided or accepted by the Foundation for my participation in the patient programs and services. In the event medical care is required for me, I am furnishing the following information:

My Insurance Company: _____
Policy Number:_____
Group Name: _____
Name of Insured:_____

I have carefully read this agreement and understand it to be a release of all claims and causes of action for my injury or damage to my property that occurs while participating in activities of Thomas/McMahan Cancer Foundation and it obligates me to indemnify the parties named for any liability for injury and damage to property caused by my negligent or intentional act or omission.

_____ _____
Signature of Patient / Participant Date