



Fax Referral Contacts
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OR
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Medical Gap Grant Program

Sponsored by the *Miles of Hope Breast Cancer Foundation* administered by Cornerstone Family Healthcare

Patients must complete this section:

Please print clearly; all questions must be answered.

Date: _____ Referred by: _____ Male Female
Patient Name: _____ D.O.B. _____
Address: _____ City: _____ State: _____ Zip: _____
Daytime Phone: _____ Cell Phone: _____
Email: _____

Patients provider must complete this section:

My patient _____ is currently undergoing treatment for Breast Cancer.
Diagnosis: _____
Date of Diagnosis: _____ Stage: _____ Treatment Rx: _____
 Patient has known metastasis Patient has no known metastasis
MD Signature: _____ Date: _____
MD Print: _____ Date: _____
MD Address: _____
MD Phone: _____ FAX: _____

Confidential Communication

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Corporate Headquarters

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Cornerstone Family Healthcare is a non-profit, multi-disciplinary community health center that believes that health care is a right and not a privilege.