GEORGIAN BAY CANCER SUPPORT CENTRE

185 Hume Street | 705-293-9570 | eselby@gbcancersupportcentre.ca

Date:_____ Referred By: _____

Referral Source: _____

MEMBER INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____ Gender: _____

Address: _____

City:_____ Province: _____ Postal Code:_____

Email: _____ Cell Phone: _____

Relationship to Cancer: _____

Cancer Type: _____

PROGRAMS OF INTEREST

- ○ Support Groups
- ○ Meditative & Mindfulness Programs
- ○ Exercise & Physical Wellness Programs
- ○ Creative Expression & Art Programs
- ○ Massage Therapy
- ○ Programs for Caregivers
- ○ Social Programs
- ○ Information, Education, & Guest Speakers
- ○ Traditional Indigenous Support Programs
- ○ Individual Services
- ○ Wig Fitting
- ○ Other_____

EMERGENCY CONTACT INFORMATION

First Name: _____ Last Name: _____

Phone Number: _____ Relationship to member: _____

Are you a Power of Attorney or Substitute Decision Maker: _____
Please type N/A if no POA or SDM

POA/SDM Name: _____

Phone Number: _____ Relationship to member: _____

CONSENT

I give consent for the Georgian Bay Cancer Support Centre to contact me using the information provided.

Signature:_____ Date: _____