



Comadre Program's mission is to empower the lives of Hispanic/Latina women and their loved ones through advocacy, education, information, resources, and support about breast health and breast cancer

LOVELACE BREAST CLINIC REFERRAL FORM

PERSON MAKING REFERRAL: (check one)

Dr. Thomas _____ Dr. Tarnower _____ Sandra Arellano, MA _____ Lena Dougherty, MA _____ Other _____

CLINIC: _____ **LOVELACE BREAST CLINIC** _____

TELEPHONE: _____

DATE OF REFERRAL: _____

HOW PATIENT INFORMED ABOUT COMADRE PROGRAM: (check one)

- 1) An explanation and/or a brochure about the FREE **Comadre A Comadre Program** has been given to me. I give my permission for the Comadre Program to have my name, address and phone numbers and to contact me about participating in the Program.

Signature: _____ Date: _____

- 2) Verbal permission obtained by patient from _____ Date: _____

PATIENT INFORMATION

Name (Please print): _____

Address: _____ City: _____ Zip Code: _____

Contact Phone numbers: home _____ cell/pager _____

Family or friend's name: _____ Telephone _____

Relationship to patient _____

Patient speaks: _____ Spanish _____ English _____ Both

Comadre Program Office Tel: 242-1222

Fax this referral form directly to our own fax machine 242-1118