Libby's Legacy
Breast Cancer
Foundation

Mammogram Access Project Application

LLBCF uses the following information to help determine need for free mammograms.
All information is kept confidential, unless otherwise stated.

Date: ________________ Name: ____

DOB: _____/_____/______ Age: _______ Ethnicity/Race: _________________

Address: ____
Street City State Zip County

Home Ph ____/_____________ Cell Ph ____/______________ Work Ph ____/______________

Can we leave a message concerning your appointment with a family member or on your answering machine? Y/N

Email address: _______________________________ **Who referred you to us?** ______________________

Are you currently employed? Y/N Do you work: part-time / full-time

If yes, who is your employer? ____

Reason for unemployment? ______________________________________Year last worked_______

Do you have insurance? Y/N If yes, who is your provider __________________________________
Group number Member Number

Primary Physician/clinic____
Name Phone number

Date of last mammogram: __________ Do you have your films? Y/N **If No, please provide the following:**

____
Name of the Radiology Center Phone number

____
Street Address City State Zip

Are you having symptoms? Y/N **If yes, please contact the Women's Center for Radiology at 407-841-0822.**

Do you have breast implants? Y/N This mobile screening will not be able to meet your needs, but we can still help!

Do you do monthly breast self-exams? Y/N Do you know how? Y/N Would you like education on breast health? Y/N

Family history of breast cancer? Y/N Who had it?_____________ How old were they @ diagnosis?____________

Personal history of breast cancer? Y/N What type?__________________ When were you diagnosed? __________

Household Income: Self $__________/**(wk/mo/yr)** Partner $ ____________/ (wk/mo/yr)

Other $ ___________ Food stamps$______ (include job income, unemployment, SSI, child support, alimony, etc…)

Rent/Mortgage $_________/month # adults in household ______ #kids in household _______________
(list ages: ___________________)

If you are over our income guidelines, a self-pay discounted rate of $80 will be applied, is this acceptable? Y/N

Patient's Statement of Understanding

I have read and understand the above and declare the information furnished by me is true and complete to the best of my knowledge. I consent to the exchange of information between Libby's Legacy Breast Cancer Foundation and other community agencies to provide needed services.

____
Signature of Patient / Responsible Party Date

I hereby authorize Libby's Legacy Breast Cancer Foundation to disclose appropriate medical information regarding my care to my primary care doctor.

____
Agency/Doctor Name

____
Signature of Patient / Responsible Party Date

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