Libby's Legacy Breast Cancer Foundation

112 Annie St. Orlando, FL 32806
Ph (407) 898-1991 Fax (407) 431-0102
www.libbyslegacy.org

Mammogram Access Project Application

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

Date: _____ Name: _____
SSN: _____-_____-_____ DOB: _____/_____/_____ Age: _____
Ethnicity/Race: _____ How do you identify? *(Select one)* _____Lesbian _____Gay _____Bisexual
___Transgender _____Heterosexual
Address: _____ City: _____ State: _____ 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 today?** _____

Are you currently employed? Y/N Do you work: part-time / full-time
If yes, who is your employer? _____
If you are not working, why not? _____Year last worked_____
Do you have insurance? Y/N
Do you have Medicaid? Y/N
Group Name_____ Member Number_____
Primary Physician/clinic_____
Name Phone Number
Date of last mammogram: _____Do you have your films/CDs? Y/N **If No, please providing the following:**

_____
Name of the Radiology Center Phone Number

_____
Street Address City State Zip Code
If you've had a prior mammogram, please list the name of the Radiology Center along with their address & phone:
_____

Are you having symptoms? Y/N
Do you have breast implants? Y/N
If you answered yes, you need to be seen in the office. This mobile screening will not be able to meet your needs, but we can still help! Contact us at 407-898-1991.

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?_____
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: _____)

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

Updated 08/18/2017