

Nomination #: \_\_\_\_\_

Status: \_\_\_\_\_



## Comfort Care Package Nomination Form

Nominee's Name: \_\_\_\_\_

Type of Cancer: \_\_\_\_\_

Treatment Start Date: \_\_\_\_\_ How long is treatment \_\_\_\_\_

Age: \_\_\_\_\_ Male or Female \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Nurse Navigator or Social Worker: \_\_\_\_\_

Care Center: \_\_\_\_\_

Please provide name of any other facility that nominee has been previously treated.

\_\_\_\_\_

Please **circle one item** your nominee would benefit from:

iPad

Beats Headphones

Please provide the address where the Comfort Care Package is to be delivered. Package will have to be signed for.

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

\_\_\_\_\_



## Comfort Care Package Nomination Form

Requestor's Information:

Your Name: \_\_\_\_\_

Your Contact Number: \_\_\_\_\_

Your Email Address: \_\_\_\_\_

Your Relationship/Role to the Nominee: \_\_\_\_\_

How did you hear about Lisa's Army? \_\_\_\_\_

---

Requestor's Signature

Print

Date

Medical Contact Information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Position/Role: Doctor, Nurse Navigator, or Social Worker

\_\_\_\_\_

---

Medical Contact Signature

Print