

### Client Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 New Client                       Established Client

### Logistical Information

Treatment Center: \_\_\_\_\_ City: \_\_\_\_\_  
 Distance (miles): \_\_\_\_\_ RTrip/OneWay    Frequency (times per week/month): \_\_\_\_\_  
 What procedure/treatments would be received? \_\_\_\_\_  
 Expected date of treatment initiation: \_\_\_\_\_ Completion: \_\_\_\_\_

### Client Feedback

Gas card(s) provided will (Please check all that apply):  
 Help keep medical appointments     Improve access to healthcare  
 Offset cost of gas                       Other: \_\_\_\_\_  
 Comments: \_\_\_\_\_

### Gas Card

How many gas card(s)? \_\_\_\_\_ Card value: \$ \_\_\_\_\_ Total: \$ \_\_\_\_\_  
 The above are to offset the cost of \_\_\_\_\_ miles traveled to receive treatment/diagnostic testing \_\_\_\_\_ times per week/month during \_\_\_\_\_ month.

With this signature, I acknowledge receipt of the above stated gas card(s) and agree to be contacted for follow-up information regarding whether this assistance helped me complete my treatment.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### ***For Referring Agency***

Agency Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Agency: \_\_\_\_\_

### ***Staff Use Only***

BCRC Staff: \_\_\_\_\_ Date: \_\_\_\_\_  
 Funding source:     Komen     BCRC     Other: \_\_\_\_\_