

Reducing Cancer Health Disparity Program

Patient Nomination Form

GTC is dedicated to reducing the gap in cancer health disparity. This program provides patients with the opportunity for comprehensive genomic profiling, regardless of their ethnic, social, and financial status.

Our practice abides by the contractual and legal obligations of health benefit plans to collect charges, co-pays, co-insurance, and deductible amounts owed by patients. Recognizing that ethnic and racial minorities, impoverished people, sexual and gender minorities (LGBT+) are typically affected more negatively with cancer and often are not covered by insurance, we have established this program of physician nominations to request complete cancer profiling (DNA+RNA). To do this, we must ask for the ordering Physician to complete this form and return to GTC. All information will be held confidential according to our HIPAA-compliant privacy policy.

Patient Information				
First Name		Last Name		Date of Birth
Address		City		State
Zip Code		Phone		

Patient Race (check one)				
<input type="checkbox"/> American Indian	<input type="checkbox"/> African American	<input type="checkbox"/> Alaskan Native	<input type="checkbox"/> Native Hawaiian	
<input type="checkbox"/> Asian	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Latino	
<input type="checkbox"/> Mixed:	_____			
		<input type="checkbox"/> Other:	_____	

Patient Sex:				
	<input type="checkbox"/> Male	<input type="checkbox"/> Female		
Sexual Orientation	<input type="checkbox"/> Heterosexual/Straight	<input type="checkbox"/> Gay	<input type="checkbox"/> Lesbian	
	<input type="checkbox"/> Bisexual	<input type="checkbox"/> Not listed above (please specify) _____		

Family Type:				
<input type="checkbox"/> Single	<input type="checkbox"/> Single parent with children	<input type="checkbox"/> Married couple or partners		
	<input type="checkbox"/> Two parent family with children	<input type="checkbox"/> Other: _____		
Marital Status:	<input type="checkbox"/> Married	<input type="checkbox"/> Cohabiting Partner	<input type="checkbox"/> Divorced or separated	
	<input type="checkbox"/> Widowed	<input type="checkbox"/> Never married		
Income (per person/household):	<input type="checkbox"/> < \$ 40,000	<input type="checkbox"/> < \$ 30,000	<input type="checkbox"/> < \$ 20,000	
Disability Status:	<input type="checkbox"/> without disability	<input type="checkbox"/> with disability: _____		
Country of Birth:	<input type="checkbox"/> US	<input type="checkbox"/> Outside US		
Drug Dependency:	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
	If Yes <input type="checkbox"/> Current	<input type="checkbox"/> History		

As a Representative of the patient, or an Ordering Physician completing this application on the patient's behalf, I hereby confirm that the above information is true and accurate.

My signature certifies that I have explained to the patient the nature and purpose of this nomination and that the patient has consented to my completing the nomination on his/her behalf.

Physician name:		Signature	
Facility			
Address of Facility		Date	
Phone Number		E-mail	