Referral Form

Your Name _____

Your Telephone Number _____

Patient Name: _____

Patient City / State _____

Patient Telephone Number _____

Diagnoses _____

Age_____ Sex □ Male □ Female

CaringBridge or other website for Patient _____

Relationship to patient _____

Pertinent Information about potential camper that you may know
(i.e. when diagnosed, where treated, current status, any treatments or operations, etc.)

_____

_____

_____

Where Treated_____

Thank you for thinking enough about our Camp, and the person you are referring, by sending us the information on this referral form.

I understand and agree that information disclosed regarding any of the individuals named in this referral form and related documents may be disclosed or otherwise released to appropriate organizations or individuals (including, but not limited to: members of Camp Debbie Lou Staff, insurance companies, and physicians) in connection with attendance at Camp Debbie Lou. I hereby confirm that the above information is true and accurate and that once accepted, I agree to update this information as you may request.

Referring Adult Name _____

Signature _____

Date _____

Mother's Name _____

Father's Name _____

Sibling Name _____ Age _____

Sibling Name _____ Age _____

Sibling Name _____ Age _____

PLEASE MAIL or FAX TO:

Camp Debbie Lou
726 Lucky Run
Latta, SC 29565
(Office) 843-752-5416
(Fax) 843-752-5982
dean@campdebbielou.com