



ACH REXALL PHARMACY APPLICATION

FAMILY INFORMATION		
Patient Name:		Date of Birth:
Parent Name(s):		
Email Address:		
Address:		
City:	Province:	Postal Code:
Telephone:	Referred By:	
HEALTH INFORMATION		
Diagnosis:	Date of Diagnosis:	
Oncologist:	Hospital/Facility:	
Primary Nurse or Social Worker (if applicable):		
REQUEST FOR FUNDING		
Item(s):		
Do you have extended health benefits to cover some of these expenses related to your treatment? YES / NO		

VERIFICATION: *By signing you are consenting to release information to Believe in the Gold*

I (Parent/Guardian) verify this information to be true:

_____ *Signature* _____ *Date*

Nurse/Social Worker/Oncologist:

_____ *Signature* _____ *Date*

NOTE: *To be approved all fields must be filled out.*

APPROVAL

Believe in the Gold:

_____ *Signature* _____ *Date*