



**S. O. S. QUESTIONNAIRE**

Date: \_\_\_\_\_

Name of deceased: \_\_\_\_\_

Your name: \_\_\_\_\_

Your relationship to deceased: \_\_\_\_\_

Your Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E Mail Address: \_\_\_\_\_

(If applicable) Number of children living at home: \_\_\_\_\_ Ages: \_\_\_\_\_

Patient's Referring Doctor: \_\_\_\_\_  
(Oncology/Radiologist/Surgeon)

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

Phone: \_\_\_\_\_

Nurse/Social Worker/Contact Person: \_\_\_\_\_

Date of Breast/Gynecological Cancer Diagnosis: \_\_\_\_\_

Please check off a service or reimbursement that may be helpful. Please number in the order of priority.

- \_\_\_\_ Catering - Dinner prepared
- \_\_\_\_ Housecleaning Service
- \_\_\_\_ Childcare
- \_\_\_\_ Funeral Expense
- \_\_\_\_ Utility Payment
- \_\_\_\_ Other (please explain)

If this is to be used for Funeral Expense please continue Date of Funeral \_\_\_\_\_

Name of Funeral Home: \_\_\_\_\_

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

Phone: \_\_\_\_\_

fax completed form to 631-539-8862