RONALD MCDONALD HOUSE REFERRAL FORM **Phone (504) 486-6668** **Fax (504) 482-1666**

Patient's Name____Home Address____

City___________________________State______Zip__________Primary Phone (____) _____________________Secondary Phone (____) ___________________

Parish/County__________________________Patient's DOB___________________Hospital______________________Campus _________________________

Diagnosis (Circle all that apply): Cancer Heart Eye Kidney Neurology Preemie **Inpatient or Outpatient**

Other (Surgical) ____ Other (Non-Surgical) ______________________________________ _____________

Guests' Names/Relationships to Patient/Date of Birth (please include date of birth for all guests):

1.____DOB:______________ 3. ____DOB:______________

2.____DOB:______________ 4. ____DOB:______________

Primary Contact Email Address: ____

Date of First Appointment:_________________Expected Arrival Date and Length of Stay:_______________________# In Party: Adults______Children__________

Daily Suggested Donation is $10.00

Referred By (full name please): __________________________ Title: (Circle One) Social Worker Doctor Nurse Nursing Supervisor Administrator Self Other

Phone Number: __________________________ Cell Number: _____________________________ Referrer Email: _______________________________________

Are there any special instructions or needs for this family? ____
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Is transportation needed? **IMPORTANT**—Please indicate the proper hospital campus for pickup/dropoff and inform family of location.__________________________

Potential families must be informed of the following prior to their stay:

- This is not a reservation. Families are accepted on a first come, first served basis.
- Family must call on the morning of the day they are due to arrive.
- Family must check in by 8:00 pm.

To be completed by RMHC Staff:

Referral Taken By: ________________________________ Date: __________________

Complete on the day the family is due to arrive: Family has confirmed? Yes No Date: ______________

Revised 2/11/2016