

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 (Check all that apply): Cancer Heart Eye Kidney Neurology Premie **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: _____

Expected Arrival Date: _____ Expected Departure Date: _____ # In Party: Adults _____ Children _____

Daily Suggested Donation is \$10.00

Referred By (full name): _____ Title: 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? _____

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: _____