



RMH CONFIDENTIAL GUEST REFERRAL FORM

On Blocked Guest List Yes No

(Please Print)

Today's Date : / /

Volunteer:			Room Number:		
Expected Date of Arrival: / /	Est. Number of Nights: _____ Act. Number of Nights: _____	Check-In (12:30pm-7:30pm) Time Expected: :	No. of Guests (including Patient) _____Adults _____Children		
Actual Date of Arrival: / /		: <input type="checkbox"/> AM <input type="checkbox"/> PM	Actual No. of Guests _____Adults _____Children		

PATIENT INFORMATION

Guest: <input type="checkbox"/> New <input type="checkbox"/> Returning (last 3 yrs)	DOB: / /	Patient's Last Name: _____ First: _____	Special Accommodations: <input type="checkbox"/> None <input type="checkbox"/> Oxygen <input type="checkbox"/> Refrigerator <input type="checkbox"/> Walker <input type="checkbox"/> Hearing <input type="checkbox"/> Wheelchair <input type="checkbox"/> Sight <input type="checkbox"/> Other_____
Reason For Treatment: <input type="checkbox"/> Lyme <input type="checkbox"/> Epilepsy <input type="checkbox"/> Premature <input type="checkbox"/> Cancer <input type="checkbox"/> Other_____		Affiliated Hospital: <input type="checkbox"/> Yale <input type="checkbox"/> St. Raphael <input type="checkbox"/> Other_____	Phone: ()
Referring Doctor:	Verified By:	Department:	Phone: ()

GUEST(S) INFORMATION

Patient Information:	Address:	Phone: ()	English Speaking? <input type="checkbox"/> Yes <input type="checkbox"/> No
Email Address: _____		<input type="checkbox"/> Adult <input type="checkbox"/> Child <input type="checkbox"/> Crib	Chicken Pox Last 21 Days? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient
Guest Information:	Address:	Phone: ()	English Speaking? <input type="checkbox"/> Yes <input type="checkbox"/> No
(Last)		<input type="checkbox"/> Adult <input type="checkbox"/> Child <input type="checkbox"/> Crib	Chicken Pox Last 21 Days? <input type="checkbox"/> Yes <input type="checkbox"/> No
(First)		Relationship:	DOB: / /
Guest Information:	Address:	Phone: ()	English Speaking? <input type="checkbox"/> Yes <input type="checkbox"/> No
(Last)		<input type="checkbox"/> Adult <input type="checkbox"/> Child <input type="checkbox"/> Crib	Chicken Pox Last 21 Days? <input type="checkbox"/> Yes <input type="checkbox"/> No
(First)		Relationship:	DOB: / /
Guest Information:	Address:	Phone: ()	English Speaking? <input type="checkbox"/> Yes <input type="checkbox"/> No
(Last)		<input type="checkbox"/> Adult <input type="checkbox"/> Child <input type="checkbox"/> Crib	Chicken Pox Last 21 Days? <input type="checkbox"/> Yes <input type="checkbox"/> No
(First)		Relationship:	DOB: / /
Guest Information:	Address:	Phone: ()	English Speaking? <input type="checkbox"/> Yes <input type="checkbox"/> No
(Last)		<input type="checkbox"/> Adult <input type="checkbox"/> Child <input type="checkbox"/> Crib	Chicken Pox Last 21 Days? <input type="checkbox"/> Yes <input type="checkbox"/> No
(First)		Relationship:	DOB: / /

IN CASE OF EMERGENCY

Name friend or relative :	Relationship to Patient:	Home Phone : ()	Cell/Work Phone: ()
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I confirm that above information is correct; I have been given a house tour and read aloud the house rules and procedures.

Patient/Guardian signature: _____

Date: _____