REFERRAL

RMHC
Greater Chattanooga

INSTRUCTIONS

Fill out ALL 4 steps of this referral. Email or Fax this referral, then call the Hotline to verify transmission and to check room availability. All check ins are by appointment, Monday through Friday ONLY.

HOTLINE:	EMAIL:	FAX:
423.778.4337	RMHC.Referral@rmhchattanooga.com	423.778.4350

STEP 1 Verifying Patient Status

Is the patient 21 years of age or younger? ☐ YES ☐ NO

Does family live 15+ miles from the hospital? ☐ YES ☐ NO

Patient's household has been COVID free for the last 24 days and no one being referred has been exposed to COVID in the past 10 days? ☐ YES ☐ NO

Are the parents/guardians requesting to stay at RMH over the age of 18? ☐ YES ☐ NO

STEP 2 Consent to Release Information

I consent to the release of the following information from _____
NAME OF HOSPITAL

to Ronald McDonald House of Greater Chattanooga, TN, Inc., for referral purposes.

Signature of Responsible Party _____ Date _____ Printed Name Of Responsible Party _____

Signature of Hospital Personnel Making Referral _____ Phone Number of Person Making Referral _____ Printed Name of Hospital Personnel Making Referral _____

STEP 3 Patient Information

Name of Patient _____ Date Of Birth of Patient _____

Patient's Diagnosis _____ Ethnicity of Patient _____

Gender of Patient:

Male ☐

Hospital _____ Patient's Unit / Room _____

Female ☐

STEP 4 Qualified Candidate for Staying at Ronald McDonald House

Date Room is Needed _____

To insure the PROPER "Waiting List" placement of this referral please furnish a date MM/DD

Estimated Stay At RMH _____

Name of Person(s) who will be staying at RMHC _____ Relationship to Patient _____

Handicap Accessible Room Needed? ☐ YES ☐ NO

Primary Language _____

Contact Phone Number (1) _____

Street Address _____

Contact Phone Number (2) _____

City _____ State of Residence _____ Zip Code _____

Contact Phone Number (3) _____

RMHC USE ONLY (OH-002)	*SCHEDULE DATE*	*SCHEDULE TIME*