



Guest Referral Form

RMHC-MVR
555 Valley Street Dayton,
OH 45404
Phone: 937-224-0047

To request services the patient's physician or a member of *4 Paws for Ability* staff must
Fax the completed Guest Referral form to RMH Guest Services at 937-496-2476.
RMH staff will review the referral and contact the family regarding their request.

TO BE COMPLETED BY THE PARENT(S) OR LEGAL GUARDIAN(S)
PARENT OR LEGAL GUARDIAN MUST ALSO SIGN AND DATE CONFIDENTIALITY AGREEMENT ON BACK

Patient Name: _____ **Patient DOB:** _____

Parent/ Guardians Name: _____ **DOB:** _____ **Relationship to Patient:** _____ **Custodial Parent:** _____
 _____ Y/N
 _____ Y/N

Additional Guests:
Only parents/legal guardians, siblings of the hospitalized patient and individuals directly involved in the patients care are eligible to receive the services offered by Ronald McDonald House.

Name:	DOB:	Relationship to Patient:
_____	_____	_____
_____	_____	_____

Does anyone listed above have or recently been exposed to an infectious disease? If so please list:

Y / N

Is anyone listed above currently being investigated by CSB, or have they been convicted of domestic violence or a crime against a child? If so please list:

Y / N

Home Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Home Phone: _____ **Cell Phone:** _____

TO BE COMPLETED BY 4 Paws for Ability STAFF
All questions must be answered and the signed confidentiality agreement returned before an offer of services can occur. Note that completion of this referral *does not* guarantee an offer of services.

Patient's Reason for Service Animal: _____ **Arrival Date:** _____ **Anticipated Stay:** _____

Does referral family have any family dynamics / issues that RMH should be aware of: _____ Y / N
Comments: _____

Completing Staff (print): _____ **Position:** _____ **Date:** _____



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CONFIDENTIALITY AND EXCHANGE OF INFORMATION

The staff of Ronald McDonald House Charities of the Miami Valley Region (RMHC-MVR) may find it necessary to obtain and exchange information with care providers at **Dayton Children's Hospital**. This information includes medical, social and demographic information that is classified as Protected Health Information (PHI) per the Health Insurance Portability Act of 1996 (HIPAA). These communications include but are not limited to telephone, fax and e-mail. These communications are limited to what is necessary to verify there is a clinical need for your family to stay at Ronald McDonald House (RMH) and to help assure that RMHC-MVR is making good decisions regarding utilization of RMH space and resources. This information is also used for the purpose of maintaining a safe environment for guests staying at RMH. Your privacy is important to us. Information obtained by RMHC-MVR will not be released to other families staying at RMH, nor will it be sold or exchanged with other third parties.

By signing this form, you understand and agree that care providers at **Dayton Children's Hospital** are authorized to provide medical, social and demographic information, for purposes as described above, to Ronald McDonald House Charities of the Miami Valley Region. You certify that you are at least 18 years of age, and you further understand and agree that this Agreement applies to the signer and all members of the signer's family for all current and future visits and stays at the Ronald McDonald House in Dayton, Ohio.

Parent or Guardian Signature

Date