Guest Referral Form

RMHC-MVR
555 Valley Street Dayton, OH 45404
937-224-0047 ext. 11

To request services the patient's physician or a member of Miami Valley Hospital 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.
A **valid state issued photo ID is required** for adults upon registration at the House.

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:** _____ **Type of Service Requested:** *Day Overnight Both*

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? Y / N If so please list: _____

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

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

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

TO BE COMPLETED BY THE HOSPITAL 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.

Hospital Dept: _____ **Patient Room #:** _____ **Anticipated Stay:** _____

Patient's Reason for Hospitalization: _____

What is the patient's criticality? *Good Fair Serious Critical*

Is the patient's reason for hospitalization currently being investigated by CSB? Y / N

In your observation does referral family appear suitable for communal living: Y / N

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 **Miami Valley 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 **Miami Valley 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**