Ronald McDonald House Charities of Southern West Virginia
Referral Form

Today's Date: _____ First Visit to House: Yes ☐ No ☐

Date of Expected Check In: _____

Referral Made By: _____ Hospital/Office: _____
Title: _____ Phone Number: _____

Patient Name: _____ Date of Birth: _____ Gender: _____

Mother's Name: _____
Date of Birth: _____ Legal Guardian: Yes ☐ No ☐

Father's Name: _____
Date of Birth: _____ Legal Guardian: Yes ☐ No ☐

Home Address: _____ County: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Distance Traveled: _____ miles **(Must be at least 50 miles)**

Reason for Hospital Stay/Appointment: _____
Attending Physician: _____ Hospital Unit: _____

Neonatal Abstinence Syndrome: Yes ☐ No ☐

Substance Abuse Treatment: Yes ☐ No ☐

Number of People in Party: _____ **(Maximum number is 4 people per room)**

Method of Payment: ☐ Self-Pay (recommended $20.00/night donation)

☐ WV Medicaid: Medicaid Number: _____

Families **MUST** present a valid photo ID to be eligible to stay at RMHC. This is a referral placing the family on our waiting list and does not guarantee the family a room. Rooming decisions are made daily once a background check has been completed. **Please note**: Additional guests not involved in the daily care of the patient will not be permitted to stay overnight.

Guest's Name: _____ Minor: ☐ Relationship to Patient: _____

Guest's Name: _____ Minor: ☐ Relationship to Patient: _____

Guest's Name: _____ Minor: ☐ Relationship to Patient: _____

Guest's Name: _____ Minor: ☐ Relationship to Patient: _____

Please fax completed form to 304-343-8385

Staff Use Only:

Referral Received: Date: _____ Time: _____ Staff Initials: _____
Background Check Completed: Date: _____ Time: _____ Results: ☐☐☐☐
Family Added to Waiting List: YES _____ NO _____ Staff Initials: _____
Family Notified: Date: _____ Time: _____ Staff Initials: _____
Comments: _____