Ronald McDonald House Charities® Piedmont Triad

Keeping families close®

Guest Referral Form

419 S. Hawthorne Road, Winston-Salem, NC 27103
PHONE: 336.723.0228 | FAX: 336.723.0302 | WEBSITE: www.rmhcpt.org

Medical Facility: **WFBH** **FORSYTH** **OTHER:** _____

Today's Date: ____/____/____ Time: _____ Hospital Admission Date: ____/____/____

Expected Discharge Date: ____/____/____ Stayed at RMHCPT before: yes no

Referred By: _____ Title: _____ Phone #: _____

Referring Unit: _____ Diagnosis: _____

Patient Medicaid Plan Name: _____ **Patient Medicaid Plan #:** _____

Screening:

- Minor Parent- eligible, special guidelines apply.
- CPS- ineligible
- Signs of Drugs / Alcohol- ineligible
- Signs of Domestic Violence- ineligible
- Behaviors inappropriate for communal living- ineligible
- Families who live in Forsyth County will be evaluated on a case-by-case basis and will only be considered under certain circumstances.

- ***Inform family that they will need to present photo ID upon check in.***
- ***Inform family that a criminal background check will be done prior to check in.***
- ***Remind family that there is a suggested $10 per night donation, if possible.***
- ***RMHCPT will call family two days before expected arrival to confirm.***

Patient's First Name _____ Last Name _____ DOB ____/____/____

Unit/Room # _____ Patient's Gender _____ **Home County** _____

Address _____

City _____ State _____ Zip _____

Mother's Name _____ DOB ____/____/_____ Cell Number _____

Father's Name _____ DOB ____/____/_____ Cell Number _____

Emergency Contact Name _____ Cell Number _____

Date Room is Needed ____/____/____ Special Needs (no stairs, wheelchair, crib, etc.) _____

# of Guests registering to stay (**no more than 5**), (**Background Checks Required**) _____

Name/Relationship to Patient: _____

CHECK IN HOURS:

Mon-Thurs 7a.m. —9p.m. | **Fri** 7a.m. – 8p.m. | **Sat** 8a.m.—8p.m. | **Sun** 2p.m.—8p.m.