 **Referral Form**

**This document must be submitted by a social worker/medical professional who considered the family suitable for housing with Ronald McDonald House Charities of the Carolinas. A new referral is needed for each individual stay. Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Insurance: If the patient has South Carolina Medicaid, please do not fill out this form. Please submit a LogistiCare Medical Request for Overnight Travel.** |

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| **Medical Facility Name:**  |  | **Department:**  |  |
| **Print Name:** |  | **Signature:** |  |
| **Email:**  |  | **Title/Position:** |  | **Phone:**  |

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| **Patient** **Full Name:**  |  | **DOB:**  |
| **Parents/ Guardians:** |  | **Phone Number(s):** |
| **Additional Occupants:** |  | **Relationship to Patient:** |
| **Address:** |  |
| **Maximum of 4 Occupants per room and one room per family.** |
| **Reason for Stay/Diagnosis:** |
| **Is anyone in the family unable to walk upstairs? Please Explain and indicate who?** |

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| **Estimated Length of Stay: # of nights**  | **New resident that has never stayed with us before?**  **New Established** |
| **AUTHORIZATION:** **I authorize RONALD MCDONALD HOUSE CHARITIES OF THE CAROLINAS’ staff to receive any communications pertinent with my Child’s /children stay. Also, all communications with my child’s/children’s medical/mental health professionals, case management staff or any other Ronald McDonald House, wherever located, deemed necessary or appropriate concerning the patient or anyone.** **in the family.** **Verbal Consent Obtained from Parents/Guardians YES NO Initials\_\_\_\_\_\_\_\_\_\_\_\_** **Please Advise the Family:****Providing photo proof of COVID 19 Testing is mandatory for all adults 18 and older not provided by us for each visit. A background check may be performed for any adult resident(s) staying with us and that no one should have any felonies pending or otherwise.** |