Ronald McDonald House Charities® Richmond

RMHC – Richmond Staff Only				
Received Date:		By:	E-ID:	
Stay	Cancel	No-Show	Wait List	Hotel

RMHC-Richmond Stay Request

To be completed by Patient Family:

Primary Guest Information

Parent/Guardian Name:	**Phone:**	**Relationship to Patient:**	
Other Parent/Guardian Name:	**Cell/Alternate:**	**Relationship to Patient:**	
Address:	**City:**	**State:**	**Zip:**
Emergency Contact (Someone Not Staying in House):	**Phone:**	**Relationship to Patient:**	

Other Guests

*All Guests 18 and Older Must Have a Valid Photo ID

Name:	Age:	Relationship:

Transportation Needed? Yes No

Do any guests have any physical limitations that would prevent them from climbing stairs? Yes No

If yes, please describe: _____

I consent to the release of the following information from _____ (enter medical facility) to Ronald McDonald House Charities of Richmond, VA, Inc. for referral purposes.

_____ Signature (Parent/Guardian)

_____ Printed Name (Parent/Guardian)

_____ Staff Initials (If Verbal Consent)

To be completed by Medical Personnel:

Stay Information

Today's Date:	Date of Arrival:	Length of Stay: Days/Weeks	Number of Guests: Adults: Children:

Patient Information

Patient Name:	**DOB:(must be 21 or younger)**	**Gender:**	**Referring Unit:**
Hospital:	**Diagnosis:**	**Physician:**	
Referring Staff Member Name and Title:	**Phone number:**	**Email**	