Referral for Which RMHC Richmond House:
☐ **CHoR House** ☐ **Monument House** ☐ **St. Mary's**

RMHC-Richmond Stay Request

Stay Information

Today's Date:	**Date of Arrival:**	**Estimated Departure Date:**	**Number of Guests:** Adults: Children:

Patient Information

Patient Name:	**DOB:(must be 21 or younger)**	**Gender:**	**Ethnicity:**
Hospital:	**Diagnosis:**	**Inpatient or Outpatient:**	

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:**

Has family given permission to share their information? **Yes** **No**

Transportation Needed? **Yes** **No**

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

If yes, please describe: _____

Referral Partner Information

Referring Staff Member Name:	**Referring Partner Unit:**	**Referring Partner Position:**
Referring Partner Phone #:	**Referring Partner Email:**	
Additional Comments:		