



Guest Referral Form

Ronald McDonald House: Dayton
555 Valley Street Dayton, OH 45404
937-224-0047 ext. 10

To request services the patient's physician or a member of Cincinnati Children's Hospital staff must
Fax the completed Guest Referral form to Ronald McDonald House: Dayton Guest Services at 937-496-2476.
Ronald McDonald House staff will review the referral and contact the family regarding their request.
A valid state-issued photo ID is required for adults upon registration at the House.

TO BE COMPLETED BY THE CAREGIVER(S) OR LEGAL GUARDIAN(S)
CAREGIVER OR LEGAL GUARDIAN MUST ALSO SIGN AND DATE CONFIDENTIALITY AGREEMENT ON BACK

Patient Name: _____ **Patient DOB:** _____ **Type of Service Requested:**
 Day Overnight Both

Ohio Medicaid ID Number: _____ **Caregiver/Guardian Name:** _____ **DOB:** _____ **Relationship to Patient:** _____ **Legal Guardian:**
 Yes No
 Yes No

Additional Guests:
Only caregivers/legal guardians, siblings of the hospitalized patient and individuals directly involved in the patient's care are eligible to receive the services offered by Ronald McDonald House.

Name:	DOB:	Relationship to Patient:
_____	_____	_____
_____	_____	_____

Does anyone listed above have or recently been exposed to an infectious disease? Yes No If so, please list: _____

Is anyone listed above currently being investigated by CSB, or have they been convicted of domestic violence, a sexual offense or a crime against a child? Yes No If so, please list: _____

Home Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Email: _____ **Cell Phone:** _____ **Secondary Phone:** _____

TO BE COMPLETED BY THE HOSPITAL STAFF
All questions must be answered and the signed confidentiality agreement returned before an offer of services can occur. Note that completion of this referral does not guarantee an offer of services.

Hospital Dept: _____ **Patient Room #:** _____ **Anticipated Stay:** _____

Patient's Reason for Hospitalization: _____ **What is the patient's criticality?**
 Good Fair Serious Critical

Is the patient's reason for hospitalization currently being investigated by CSB? Yes No

In your observation does referral family appear suitable for communal living: Yes No

Does referral family have any family dynamics/issues that Ronald McDonald House should be aware of: Yes No

Comments: _____

Completing Staff (print): _____ **Position:** _____ **Date:** _____



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CONFIDENTIALITY AND EXCHANGE OF INFORMATION

The staff of Ronald McDonald House Southwest Ohio may find it necessary to obtain and exchange information with care providers at **Cincinnati Children's Hospital**. This information includes medical, social, and demographic information that is classified as Protected Health Information (PHI) per the Health Insurance Portability Act of 1996 (HIPAA). These communications include but are not limited to telephone, fax and e-mail. These communications are limited to what is necessary to verify there is a clinical need for your family to stay at Ronald McDonald House and to help assure that Ronald McDonald House Southwest Ohio is making good decisions regarding utilization of Ronald McDonald House space and resources. This information is also used for the purpose of maintaining a safe environment for guests staying at Ronald McDonald House. Your privacy is important to us. Information obtained by Ronald McDonald House Southwest Ohio will not be released to other families staying at Ronald McDonald House, nor will it be sold or exchanged with other third parties.

By signing this form, you understand and agree that care providers at **Cincinnati Children's Hospital** are authorized to provide medical, social and demographic information, for purposes as described above, to Ronald McDonald House Southwest Ohio. You certify that you are at least 18 years of age, and you further understand and agree that this Agreement applies to the signer and all members of the signer's family for all current and future visits and stays at the Ronald McDonald House in Dayton, Ohio.

Caregiver or Guardian Signature

Date