Ronald McDonald House
RMHC Southern California
LOS ANGELES

REFERRAL EXTENSION

Office Use Only
Last Visit _______
ID _____________
Room _______

Extension Date: ____________

Patient's Last Name: _________________________ First Name: _________________________ Date of Birth: ___________

Medical Profile

Status: ☐ Inpatient ☐ Outpatient Diagnosis or Department: ____

Critical Care: ☐ NICU/NICCU ☐ PICU ☐ CTICU

Reason for Extension: ____

Hospital or Facility: ___________________________________ Doctor: ___________________________________

Extension Request

A guest family's stay at Los Angeles Ronald McDonald House (LARMH) may be extended past their original departure date if the patient remains inpatient, is outpatient with 3+ medical appointments per week and if the family continues to follow House guidelines. **Due to high demand for rooms, a family's eligibility should be reassessed every 28 days and they must check out when treatment is finished.**

Extended departure date ___________ (Must be ≤28 days from today's date)

I certify this patient's treatment is in line with LARMH eligibility guidelines and the family will need to extend their stay. I understand the approval of this extension request is at the discretion of LARMH management team and is ***subject to room availability.***

____________________________________ ____________
Signature of Medical Professional Date

Referred By: ____________________________________ Title: _____________________________

Referral Contact Phone: _____________________ Email: ____

Submit completed form to LARMH-RoomRequest@rmhcsc.org or by fax to 323-663-8550