

Pasadena Ronald McDonald House
763 S. Pasadena Avenue; Pasadena, CA 91105

Room Request Form

Please complete entire form and **fax** to: PRMH Guest Services: 626-585-1688 or **call** 626-204-0402 or 626-204-0401

Or email it to: PRMH-RoomRequest@rmhcsc.org

General Information

Date of Request: _____ Returning Family? Yes / No

Patient's Full Name: _____

Patient's Date of Birth: _____ Patient's Age _____ Sex? Male / Female

Accompanying Parent(s) or Guardian: _____

Valid ID (i.e. CA ID, Drivers License) _____ Exp. Date _____ ID # _____

Home Address: _____ City _____

County _____ State _____ Zip _____

Home Phone: () _____ Cell: () _____ Other: () _____

Medical Information

Diagnosis: _____ Referring Hospital: _____

Current Hospital: _____ Hospital Unit: _____

Reason for Visit: _____

Child is: Inpatient _____ Outpatient _____

Does/will the patient have a compromised immune system? Yes _____ No _____

Wheelchair Needs? _____

Social Worker: _____ Phone: _____

Does the family have an open/pending CPS Case? Yes _____ No _____

Method of Payment

Cash/VISA/MC: (please circle) insurance (Name): _____

Insurance subscriber ID # _____ Telephone # _____

CCS Yes or No: (please circle) Case worker: _____ County: _____

Sponsored: (Name) _____ Comments: _____

Request Information

Arrival Date: _____ Arrival Time: _____ Estimated Departure Date: _____

Total number of individuals staying at the House: Adults _____ Children _____

Names and relationship to patient of **all** individuals staying at the House:

Name:	Relationship to patient:	Age:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Verification of Eligibility: This family meets the eligibility requirements to be a guest of PRMH including: 1) no current or past history of drug/ alcohol abuse/ no child abuse, violent/ criminal behavior 2) no infectious disease or physical condition that might endanger the health of other residents in the PRMH communal environment, particularly other guests who may be immune- suppressed. Referring Social Worker / RN: _____ Hospital _____ Phone # _____

To be completed by Parent or Guardian of patient: I agree to release the above information to Pasadena Ronald McDonald House. I also give permission for the hospital and PRMH to share information when the patient is discharged, deceased, transferred, receiving home health services, or about our family's eligibility to stay at PRMH.

Signature/ Printed Name (Parent)/ Adult Guardian

Date

IMPORTANT INFORMATION FOR FAMILIES:

Check in hours: 9:00 am – 9:00 pm (**Check out time is 12:00 pm**)

Room request does not guarantee a reservation. Call for confirmation. 626-204-0402 or 626-204-0401

\$25 fee per night requested + \$10 cash key deposit for each room key (**required**)

For office use only

Date: _____ Proposed Room # _____

Request Confirmed: _____ Request cancelled: _____ **Reason:** _____ No show _____ No room
_____ Transportation _____ Distance

Staff Signature: _____