Los Angeles Ronald McDonald House

Print

ROOM REQUEST FORM

Please complete entire form and fax to: Room Operations @ 323-663-8550

General Information:

Date of Request: _____ **Returning Family**? No. Family New to the House

Patient's Last Name: _____ First Name: _____ Middle Initial: _____

Patient's Date of Birth: _____ **Sex**: ☐ Male ☐ Female

Accompanying Parent or Guardian Last Name: _____ First Name _____

Home Address: # and Street _____ Apt: _____ City: _____ State: _____ Zip:_____

Home Phone: _____ **Cell Phone**: _____ **Other phone** _____ **(Please specify)**

Medical Information: (Please check all that apply)

Diagnosis: Cancer Other Diagnosis:_____(Please specify)

Hospital: CHLA Other:_____(Please specify)

Referred By: Name: _____ Phone: _____ Email: _____(Required)

Title of the referring Person: _____ Other : _____(Please specify)

Method of Payment Self Pay $25

Sponsor Agency:_____ Contact Person:_____ Phone( )_____

Request Information

Arrival Date: _____ **Estimated Departure Date:**_____

Total number of individuals staying at the house: (Maximum 4 to a suite) No of Adults: _____ No of Children: _____

Wheelchair accessible room required? ☐ Smoking area required? ☐

Any other Special Needs: _____

Important Information for Family

Check-in hours: 2:00pm- 8:00pm **Check-out time: 12 noon** **$20 dollar deposit requested at time of check in.**

MEDICAL INFORMATION RELEASE CONSENT

I hereby give the staff of the Ronald McDonald House Charities of Southern California my permission to request information from and to release information to the staff of the hospital where my child is receiving medical care.

Print

_____ _____ _____

Signature Relationship to Patient Date

FAMILY MUST CALL 1 DAY IN ADVANCE TO CONFIRM ROOM AVAILABILITY - 323-644-3060

For office use only:

Date: _____ **(check appropriate box for action taken)** **EC: AA A C H O____**

Request confirmed **Request cancelled** **No show** **No room** **Staff signature**_____

/pk

Revised 2/20/12