Institute: _____

THE CHILDREN'S INN AT NIH
7 West Drive, Bethesda, Maryland 20814*
Phone: 301-496-5672
Facsimile: 301-496-4421

Date of Referral: _____

PLEASE PRINT

Resident Information/Referral Form

Resident (Patient)

Name: _____ Gender: __ F __M
Last Name First Name Middle Name/Initial

Address: _____

_____
(City) (State) (Zip) (Country, if foreign)

Diagnosis: _____ Date of Birth: _____

Guardian Name(s): _____

(Please give full names and relationship to patient; list all guardians)

Address: _____

_____
(City) (State) (Zip) (Country, if foreign)

Telephone Number(s): (Include Area Code) (Location: Home, office, other)

_____ _____

_____ _____

Email: _____

On Call Medical Service Coverage:	_____	**Phone:**	_____
NIH Doctor:	_____	**Phone:**	_____
Social Worker:	_____	**Phone(s):**	_____
Clinic/In-Patient Unit:	_____	**Phone:**	_____
Research Nurse:	_____	**Phone:**	_____
Patient Care Coordinator:	_____	**Phone:**	_____

Name of person completing form: _____

Reservation: Information for first visit to The Inn

Inn arrival date: _____ Inn departure date: _____

Expected time of arrival at The Inn: _____ (Must arrive by 7 pm on first visit)

☐ Check if this patient is enrolled in a protocol that may require a stay of 120 days or more at The Inn.

First clinic appointment date: _____ Time: _____

Note: Residents may come to The Inn no more than 24 hours before FIRST appointment and may stay no more than 24 hours after their final clinic appointment

Relations accompanying patient:

Name Relationship to Patient Date of Birth (under 18)

_____

_____

_____

Total number to stay at The Inn for this reservation: _____

Is the patient (or any family member) in a wheelchair/crutches/special needs? __ Yes ___No

If language is barrier for this family, what arrangements have been made for interpreter on arrival?:

_____