FISHER HOUSE REFERRAL FORM

Patient Name:____________________________ Ward/Room:__________ Ward/Room Phone #:___________
(Last Name, First Name)

Grade or Sponsor's Grade:_________ SSN(Last 4Numbers):_______ Estimated Length of Stay:__________

Check all that apply: I = VSI/SI ____ II = Life Threatening Surgery/Illness____
III = Patient Undergoing Treatment/Evaluation____ IV = No Friends/Family in Local Area____

Distance traveled (> 40 Miles) Yes (__) No (__) Family has friends/family in local area: Yes (__) No (__)

Can family pay commercial lodging rates: Yes (__) No (__) Can family pay FH service fee: Yes (__) No (__)

OIF/OEF: Yes (__) No (__) Air Evac: Yes (__) No (__) Funded Orders: Yes (__) No (__)

Family has transportation: Yes (__) No (__)

Hardship or other assistance needed: Yes (__) No (__) if yes, also refer to Chaplains, AER, Red Cross, ACS

Any exposure to a recent contagious illness (Chicken Pox, Flu, Measles, Hepatitis, etc.) Yes (__) No (__)

Fill out the number of guest(s) and Names of Patient's caregiver seeking lodging at the Fisher House:

(Name)	(Relationship to patient)	(Age if under 21)
1.		
2.		
3.		
4.		

Location where guest are staying:______________________
Phone number where guest can be contacted:____________

Do guest(s) have any special needs: ____
____

STAFF NOTES

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Healthcare Provider's Name (Print & Sign): ______________________________________ Date:__________

Instructions: Patient's families for whom Fisher House services are appropriate, may be identified by a healthcare provider, chaplains or the American Cross at the medical facility.

Attachment FH 1