RONALD MCDONALD HOUSE CHARITIES® CENTRAL OHIO

FAMILY IS TO COMPLETE REFERRAL FORM
Fax (614) 227-3764 Phone (614) 227-3734 (call to confirm receipt)

Patient Name_____ Patient Date of Birth_____

Street Address, City, State, Zip_____

County_____ Phone _____Name of Custodial Guardian (of patient) _____

Date room needed _____ Expected Number of Nights_____ Patient's Hospital Unit ___ ___Bed #_____

Previous Resident at Ronald McDonald House Columbus? Yes __No__ Handicapped Accessible Room? _____

Name of person/unit submitting referral _____ Contact phone #_____

- Only direct caregivers of the patient will be considered for accommodations at Ronald McDonald House
- This request is for same-day accommodations only; route advanced requests through Nationwide Children's Hospital Welcome Services at (800)792-8401
- Adolescents (under 18 years) staying in the House must be child or grandchild of requesting guardians (biological, foster or adopted). Any exceptions will need to be approved in advance by RMHC Operations
- Has anyone requesting accommodations been charged/convicted of a crime of violence, theft, domestic violence, child abuse, illegal drugs or a misdemeanor/felony of any kind? Yes____ No___
  - If yes, please indicate date and type of infraction:
- Are you or anyone planning to stay at RMHC currently on probation or parole? Yes___ No____
- RMHC cannot accept anyone with a conviction or on-going investigation for domestic violence or sexual abuse. RMHC reserves the right to refuse admittance to anyone who is currently on probation, parole, has been convicted of a felonious crime or any of the following:
  - crime of theft
  - crime of violence/domestic violence
  - crime against a child
  - crime involving illegal substances
- Upon approval of this request, one room is granted per family. Each room has a 4-person occupancy limit
- In order to continue providing this vital service, a $20 donation is requested for each night of accommodations

Please use full legal name, including children. All guests 18 and older must provide a photo ID at registration

First Name	Last Name	Middle	Relationship to Patient	Date of Birth	Signature*
1.					
2.					
3.					
4.					

*** Each signature above is a statement of understanding that a thorough background check will be conducted on all individuals requesting accommodations**

Internal use only:

EPIC:__ CH:___ SMF:___ Wait List: ____ FSM Initials:_____ Date/Time Received: _____ Time Called Unit:_____