



Request for Accommodation

Referral Information

Medical referral made by: _____

Unit/Hospital: _____ Phone: _____

Family Information

Parent(s)/guardian(s) name(s): _____

City/Town: _____ Province: _____

Home phone: _____ Cell (if known): Mom: _____ Dad: _____

E-mail address: _____

Patient Information

Patient's name: _____ Birth date: _____

Please check one: In-patient Out-patient

Nature of illness: _____

Accommodation Information

Date of arrival: _____ Anticipated date of departure: _____

Number of parents/guardians staying: _____

Number of children (other than patient) staying at RMHC and ages of each child: _____

Please Note: All high-risk pregnant moms are to be accompanied by an adult caregiver for the duration of their stay or have their doctor complete an RMHC high risk pregnancy waiver.

****Third party billing must be arranged prior to arrival.***

****Families must call 24 hours before arrival to confirm space.***