Pasadena Ronald McDonald House

763 South Pasadena Avenue, Pasadena, CA 91105

Room Request Form

Please complete entire form and **fax** to: Vicky Garcia @ 626-585-1688 or **call** 626-204-0401

General Information

Date of Request: _____ Returning Family? Yes / No

Patient's Full Name: _____

Patient's Date of Birth: _____ Patient's Age_____ Sex? Male / Female

Accompanying Parent(s) or Guardian: _____

Valid ID (i.e. CA ID, Drivers License) _____ Exp. Date _____ID #_____

Home Address: _____City_____ County_____ State_____ Zip_____

Home Phone: ( ) _____ Cell: ( ) _____Other: ( ) _____

Medical Information

Diagnosis: _____ Referring Hospital: _____

Current Hospital: _____ Hospital Unit: _____

Child is: Inpatient _____ Outpatient _____

Does/will the patient have a compromised immune system? Yes _____ No _____

Social Worker/medical personnel: _____ Title: _____

Phone: _____ Wheelchair Needs? _____

Method of Payment

Cash/VISA/MC: (please circle) insurance (Name): _____

Insurance subscriber ID # _____ Telephone # _____

CCS Yes or No: (please circle) Case worker: _____ County: _____

Sponsored: (Name) _____ Comments: _____

Does the family have an open/pending CPS Case? Yes _____ No _____

Request Information

Arrival Date: _____Arrival Time: _____ Estimated Departure Date: _____

Total number of individuals staying at the house: Adults_____ Children _____

Names and relationship to patient of **all** individuals staying at the House:

Name:	Relationship to patient:	Age:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Verification of Eligibility: This family meets the eligibility requirements to be a guest of PRMH including: 1) no current or past history of drug/ alcohol abuse/ no child abuse, violent/ criminal behavior 2) no infectious disease or physical condition that might endanger the health of other residents in the PRMH communal environment, particularly other guests who may be immune- suppressed.

Referring Social Worker/RN/medical personnel: _____ Hospital _____

Phone #_____

To be completed by Parent or Guardian of patient: **I agree to release the above information to Pasadena Ronald McDonald House. I also give permission for the hospital and PRMH to share information when the patient is discharged, deceased, transferred, receiving home health services, or about our family's eligibility to stay at PRMH.**

_____ _____

Signature/ Printed Name (Parent)/ Adult Guardian **Date**

IMPORTANT INFORMATION FOR FAMILIES:
Check in hours: 9:00 am – 9:00 pm (**Check out time is 12:00 pm)**
Room request does not guarantee a reservation. Call for confirmation. 626-204-0401
The nightly fee is $15 + $10 cash key deposit for each room key **(required)**

For office use only:
Date: _____ Proposed Room #_____ EC: AA__ A__ C__ H__ O__

Request Confirmed: _____ Request cancelled: _____ **Reason**: ____ No show ____ No room

Staff Signature: _____ ____ Transportation ____ Distance