Staff Use Only
Date Referral Received:
Received By:
Entered in GRMHIS By:

RMHCA Edmonton Family Referral Form

Patient Information

☐ New Family ☐ Returning Family

Patient Surname:	Patient Given Name:
Sex: ☐ Male ☐ Female ☐ Unborn	Date of Birth:
Diagnosis *(please be as specific as possible*:	Reason for Visit *(i.e. surgery, appointments, please be as detailed as possible)*:

Hospital:	Unit:	Status (choose one): ☐ Admitted ☐ Outpatient

First Date Room is Needed:	Date of First Appointment:	Estimated Length of Stay:

Has any family member recently had or been exposed to a communicable illness?

☐ No ☐ Yes, provide details:

Additional Information

Street Address:	City:	Province:	Postal Code:

Home Phone:	Local Contact Phone:
Parent/Guardian Surname:	Parent/Guardian Given Name:
Relationship to Child:	Birth Date of Parent/Guardian:
Email Address:	Cell Phone:
Parent/Guardian Surname:	Parent/Guardian Given Name:
Relationship to Child:	Birth Date of Parent/Guardian:
Email Address:	Cell Phone:

Other Family Members Staying

Full Name	Relationship to Child	Birth Date

Additional Information/Special Requests (i.e. mobility or language considerations, etc.)

Method of Payment

☐ Self-Payment	☐ Agency, please specify: If funding is approved after a family begins their stay at RMHCNA or after they have checked out, please ensure that this information is shared with our Family Services team.

Referring Medical Professional/Social Worker Information

Name	Hospital:	Position:

Phone:	Email:
Edmonton Hospital Social Worker:	Preferred Confirmation Method: ☐ Email ☐ Telephone

Please note that only families who are considered to be suitable for communal living at RMHCNA should be referred to stay.

Please send completed forms to familyservices@rmhcna.org or fax to 780-433-6201 when completed.