



Referral Form

Date: _____

Patient Full Name:		DOB:
General Diagnostic Category:		
Mother/Guardian Full Name:		DOB:
Father/Guardian Full Name:		DOB:
NOTE: Please advise that all family members and their guests (over 19) will be asked to confirm in writing that they have no criminal convictions and/or under any current investigation. If criminal convictions/ investigations exist a separate process must be followed.		

PERMANENT ADDRESS

Street Address:			
City/Town:	Province:	Postal Code:	
Phone Number (s) you can be reached on at all times:	Cell: Cell: Home:	Email:	

ACCOMMODATION REQUIRMENTS:

First Night Needed:	Estimated Length of Stay: # of nights	Stayed at Ronald McDonald House NL before? <input type="checkbox"/> YES <input type="checkbox"/> NO
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FAMILY AUTHORIZATION:

I authorize Ronald McDonald House Operations staff to receive and communicate with my Child's medical institution, medical and mental health professionals, health personnel, social agency staff or any other Ronald McDonald House, wherever located, any pertinent information which Ronald McDonald House deems necessary or appropriate concerning the patient or anyone in my family. <input type="checkbox"/> YES <input type="checkbox"/> NO Signature _____ or Verbal Consent Obtained _____
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REFERRED BY: A social worker or medical professional who has spoken with the family and considers the family suitable for communal living at Ronald McDonald House.

Full Name: Print		Signature:	
Email:		Medical Department:	Phone:

Ronald McDonald House Charities Newfoundland and Labrador
P.O. Box 28091, St. John's, NL, A1B 1X0

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