Ronald McDonald House® Winston-Salem

Keeping families close®

Guest Referral Form

419 S. Hawthorne Road, Winston-Salem, NC 27103
PHONE: 336.723.0228 | FAX: 336.723.0302 | WEBSITE: rmhws.org

Medical Facility: **WFBH** **FORSYTH** **OTHER:** _____

Today's Date: ____/____/____ Time: _____ Hospital Admission Date: ____/____/____

Expected Discharge Date: ____/____/____ Stayed at RMHWS before: yes no

Referred By: _____ Title: _____ Phone/Pager #: _____

Referring Unit: _____ Diagnosis: _____

Screening:

- Minor Parent- eligible, special guidelines apply
- CPS- ineligible
- Signs of Drugs / Alcohol-ineligible
- Signs of Domestic Violence-ineligible
- Behaviors inappropriate for communal living-ineligible
- Families who live in Forsyth County will be evaluated on a case-by-case basis and will only be considered under certain circumstances
  - ***Inform family that they will need to present photo ID upon check in.***
  - ***Inform family that a criminal background check will be done prior to check in.***
  - ***Remind family that there is a suggested $10 per night donation, if possible.***
  - ***RMHWS will call family two days before expected arrival to confirm.***

Patient's First Name _____ Last Name _____ DOB ____/____/____

Unit/Room # _____ Patient's Gender ____ Home Phone _____

Home County _____ Address _____

City _____ State _____ Zip _____

Mother's Name _____ DOB ____/____/____ Cell Number _____

Father's Name _____ DOB ____/____/____ Cell Number _____

Emergency Contact Name _____ Cell Number _____

Date Room is Needed ____/____/____ Special Needs (no stairs, wheelchair, crib, etc.) _____

# of Guests registering to stay (**Background Checks Required**) (**no more than 5**) _____
Name/Relationship to Patient: _____
_____

CHECK IN HOURS:
Mon-Fri 9 a.m. —8 p.m. | **Saturday** 9 a.m.—1 p.m. | **Sunday** 2 p.m.—8 p.m.