ST. LOUIS HavenHouse

Phone: 314.434.5858 Fax: 314.434.6541
www.havenhousestl.org

HOSPITAL REFERRAL

Please fax this completed form to HavenHouse St. Louis

Hospital:
Doctor:
Patient Department:
Person Referring:
Phone Number:

PAYMENT INFORMATION

Who is responsible for daily fee? Check one and fill out.

☐ Family (Self-pay)

☐ Hospital: _____

☐ Other: _____

Additional Information:

Check-in Date:
Check-out Date:

PATIENT INFORMATION

Patient Name:
Patient D.O.B.
Guardian Name (N/A, if self):
Address: City: State: Zip:
Phone Number:
Alt. Phone Number:

Additional Patient Information:

LIST ALL INDIVIDUALS STAYING IN THE ROOM
******One must be 21 years or older******

Name	Relationship to Patient	Age

Can all guests use **stairs**?	Need **shuttle** to and from hospital?	Need **dinner** night of arrival?	Upgrade to **TV Room**? (Additional Charge)
☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**

Other Guest **Needs:**

OFFICE USE ONLY