ACCOMMODATION REQUEST FORM

Fax: 03 377 3414 / Email: familyroom@rmhsi.org.nz / Ph: 03 214 8910

Name of Referrer _____ Medical Facility _____ Ward _____

PATIENT INFORMATION

If this application relates to a High Risk Pregnancy the patient will be the pregnant mother and a clinician's letter of confirmation will be required.

First Name:

Surname:

Date of Birth: ☐ Male ☐ Female

MOH Number*:

*Registration for accommodation subsidies under the National Travel Assistance Policy

NHI Number:

New or Returning Family?:

Ethnicity:

Date of Arrival:

Expected Date of Departure:

DIAGNOSIS

- ☐ Accident
- ☐ Antenatal
- ☐ Auto Immune
- ☐ Burns
- ☐ Cardiac
- ☐ Cystic Fibrosis
- ☐ ENT
- ☐ Gastro
- ☐ Liver/Kidney
- ☐ MRI/X-Rays
- ☐ Neurological
- ☐ Neonatal
- ☐ Gestation
- ☐ Medical
- ☐ Oncology
- ☐ Opthalmology
- ☐ Orthopaedic
- ☐ Psychological
- ☐ Respiratory
- ☐ Surgical
- ☐ Other (please specify) _____

FAMILY CONTACT DETAILS

Address:

Suburb:

City: Postcode:

Phone (home):

Phone (mob):

Email:

EMERGENCY CONTACT DETAILS

This must be someone who is NOT staying at Ronald McDonald House South Island

First Name:

Surname:

Relationship:

Phone (home):

Phone (mob):

Email:

ACCOMMODATION REQUIREMENTS

ADULTS

First Name:

Surname:

Relationship to Patient:

Date of Birth: ☐ Male ☐ Female

First Name:

Surname:

Relationship to Patient:

Date of Birth: ☐ Male ☐ Female

SIBLINGS

First Name:

Surname:

Relationship to Patient:

Date of Birth: ☐ Male ☐ Female

First Name:

Surname:

Relationship to Patient:

Date of Birth: ☐ Male ☐ Female