

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

- | | |
|---|--|
| <input type="checkbox"/> Accident | <input type="checkbox"/> Neurological |
| <input type="checkbox"/> Antenatal | <input type="checkbox"/> Neonatal |
| <input type="checkbox"/> Auto Immune | <input type="checkbox"/> Gestation |
| <input type="checkbox"/> Burns | <input type="checkbox"/> Medical |
| <input type="checkbox"/> Cardiac | <input type="checkbox"/> Oncology |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Ophthalmology |
| <input type="checkbox"/> ENT | <input type="checkbox"/> Orthopaedic |
| <input type="checkbox"/> Gastro | <input type="checkbox"/> Psychological |
| <input type="checkbox"/> Liver/Kidney | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> MRI/X-Rays | <input type="checkbox"/> Surgical |
| <input type="checkbox"/> 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