Ronald McDonald House South Island

Ronald McDonald Family Room
SOUTHLAND HOSPITAL

Accommodation Request Form

Email completed form to: familyroom@rmhsi.org.nz
Phone: 03 214 8910

Name of Referrer _____ Medical Facility _____ Ward _____

Referrer Phone _____ Referrer Email _____

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

Is patient eligible for accommodation subsidy? ☐ Yes ☐ No

NHI Number: _____

New or Returning Family?: _____

Ethnicity: _____

Date of Arrival: _____

Expected Date of Departure: _____

If ACC – Reference No: _____

FAMILY CONTACT DETAILS

Address: _____

Suburb: _____

City: _____ Postcode: _____

Phone (home): _____

Phone (mob): _____

Email: _____

DIAGNOSIS

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

WELLNESS CHECK

Due to the communal nature of our accommodation, and in the interests of keeping our families safe, we ask that you limit the number of people booked to stay with us to essential caregivers/family members only (one support person).

Do you currently have an elevated temperature of 37.5°C or higher, cough, sore throat, shortness of breath of other flu-like symptoms, such as nausea, vomiting or diarrhoea? ☐ Yes ☐ No

Have you been told by a healthcare provider or public health official that you should self-quarantine due to potential COVID-19 exposure(s) or that you are suspected of having COVID-19? ☐ Yes ☐ No

Are all guests full immunised (received 2 doses of MMR vaccine)? ☐ Yes ☐ No

ACCOMMODATION REQUIREMENTS

ADULTS

Number _____

First Name: _____

Surname: _____

Relationship to Patient: _____

Date of Birth: _____ ☐ Male ☐ Female

ADULTS

First Name: _____

Surname: _____

Relationship to Patient: _____

Date of Birth: _____ ☐ Male ☐ Female

Please complete on next page >

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ACCOMMODATION REQUIREMENTS *Continued*

SIBLINGS

Number

First Name:

Surname:

Relationship to Patient:

Date of Birth: ☐ Male ☐ Female

SIBLINGS

First Name:

Surname:

Relationship to Patient:

Date of Birth: ☐ Male ☐ Female

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: