

# Accommodation Request Form

Email completed form to: [admin@rmhsi.org.nz](mailto:admin@rmhsi.org.nz)

Phone: 03 377 3311 | Fax: 03 377 3414

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: \_\_\_\_\_

## ACCOMMODATION REQUIREMENTS

**ADULTS** \_\_\_\_\_ Number \_\_\_\_\_

First Name: \_\_\_\_\_

Surname: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  Male  Female

## DIAGNOSIS

Accident  Neurological

Antenatal + *Current Weeks Gestation:* \_\_\_\_\_

Auto Immune  Neonatal

Burns  Medical

Cardiac  Oncology

Cystic Fibrosis  Ophthalmology

ENT  Orthopaedic

Gastro  Psychological

Liver/Kidney  Respiratory

MRI/X-Rays  Surgical

Other (please specify) \_\_\_\_\_

## 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  Yes  No temperature of 37.5°C or higher, cough, sore throat, shortness of breath or other flu-like symptoms, such as nausea, vomiting or diarrhoea?

Have you been told by a healthcare  Yes  No 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?

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

## ADULTS

First Name: \_\_\_\_\_

Surname: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  Male  Female



**Ronald  
McDonald  
Family Room®**  
SOUTHLAND HOSPITAL

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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: \_\_\_\_\_