SECU FAMILY HOUSE AT UNC HOSPITALS - REFERRAL FORM

Instructions: Download this form from **www.secufamilyhouse.org/hospital**. A nurse, social worker, surgery coordinator, chaplain, etc. must complete this form. **To submit**: Send **by fax** to **919-918-3830**, or **email** to **admissions@secufamilyhouse.org.**

Notes: Please advise the patient/family that Family House is **NOT** free**,** and this referral is **NOT** a reservation; they are put on a waiting list**.** Family House staff will contact the patient/family regarding next steps. Note special needs in the "Comments" section(s).

Please complete all fields: Incomplete or illegible forms will be returned.

PATIENT INFORMATION

First date housing is needed	Estimated no. of nights	E-Mail
Last name	**First** Name	Gender

Date of birth ***(Patient must be at least 18)***		Cell phone	
Street		Home phone	
City	State/Country	County (NC only)	Zip:

Has the patient or the patient's family ever stayed at Family House?	☐ Yes ☐ No	Comments:
Will the patient be staying at Family House?	☐ Yes ☐ No	Comments:
Is the patient currently hospitalized?	☐ Yes ☐ No	Comments:
Will the patient be receiving outpatient treatment or tests?	☐ Yes ☐ No	Comments:

DIAGNOSIS INFORMATION

Diagnosis/Reason for Medical Care (select one)

☐ Abdominal Transplant	☐ Cardiology-related treatment	☐ Neurology-related	☐ Trauma (please specify)
☐ Bone Marrow/Stem Cell Transplant	☐ Eating Disorder	☐ Perinatal Psychiatry	
☐ Burn Treatment	☐ Heart Transplant	☐ Surgery (non-cancer related)	☐ Other (please specify)
☐ Cancer-related surgery or treatment	☐ Lung Transplant		

GUEST INFORMATION

Standard Rooms accommodate up to three (3) people. Suites accommodate up to four (4) people.

Please identify the Primary Guest (**if other than the patient**) who will stay at Family House

Name of Primary Guest and Address (if different from patient's)	Relationship to Patient	Cell Phone Number
1. Name		
Address		
Names of Other Guests	**Relationship to Patient**	**Cell Phone Number**
2.		
3.		

HOSPITAL INFORMATION - *REQUIRED*

Name and Title of Staff Completing this Form		
Phone No.	Pager No.	Fax No.
Physician's Full Name:		

Thank you for completing this form accurately, legibly, and completely!

SECU Family House at UNC Hospitals, 123 Old Mason Farm Road, Chapel Hill, NC 27517

www.secufamilyhouse.org | **919-932-8000** (phone) | **919-918-3830** (fax)

FOR OFFICE USE:

Volunteer/Staff Name: _____ Date Processed: _____ Check When Done: ☐ Phone Call ☐ Letter Sent

Revised 4/21/21