

## SECU FAMILY HOUSE AT UNC HOSPITALS - REFERRAL FORM

**Instructions:** Download this form from [www.secufamilyhouse.org/hospital](http://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](mailto: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.

<b>PATIENT INFORMATION</b>					
First date housing is needed		Estimated no. of nights		E-Mail	
Last name			First Name		Gender
Date of birth ( <i>Patient must be at least 18</i> )				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?			<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:	
Will the patient be staying at Family House?			<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:	
Is the patient currently hospitalized?			<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:	
Will the patient be receiving outpatient treatment or tests?			<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:	
<b>DIAGNOSIS INFORMATION</b>					
Diagnosis/Reason for Medical Care (select one)					
<input type="checkbox"/>	Abdominal Transplant	<input type="checkbox"/>	Cardiology-related treatment	<input type="checkbox"/>	Neurology-related
<input type="checkbox"/>	Bone Marrow/Stem Cell Transplant	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	Perinatal Psychiatry
<input type="checkbox"/>	Burn Treatment	<input type="checkbox"/>	Heart Transplant	<input type="checkbox"/>	Surgery (non-cancer related)
<input type="checkbox"/>	Cancer-related surgery or treatment	<input type="checkbox"/>	Lung Transplant	<input type="checkbox"/>	Trauma (please specify)
				<input type="checkbox"/>	Other (please specify)
<b>GUEST INFORMATION</b>					
<i>Our rooms accommodate <u>no more than three (3)</u> people, including the patient and any children.</i>					
Please identify the Primary Guest ( <b>if other than the patient</b> ) 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.					
<b>HOSPITAL INFORMATION - REQUIRED</b>					
Name and Title of Staff Completing this Form					
Phone No.		Pager No.		Fax No.	
Physician's Full Name:					
<b>Thank you for completing this form accurately, legibly, and completely!</b> SECU Family House at UNC Hospitals, 123 Old Mason Farm Road, Chapel Hill, NC 27517 <a href="http://www.secufamilyhouse.org">www.secufamilyhouse.org</a>   <b>919-932-8000</b> (phone)   <b>919-918-3830</b> (fax)					
<b>FOR OFFICE USE:</b>					
Volunteer/Staff Name: _____ Date Processed: _____ Check When Done: <input type="checkbox"/> Phone Call <input type="checkbox"/> Letter Sent					