

SECU FAMILY HOUSE AT UNC HOSPITALS - REFERRAL FORM

Instructions: Download this form from www.secufamilyhouse.org/hospital. A nurse, care manager, social worker, surgery coordinator, 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 the next steps.

*****UNC STAFF MUST FILL OUT FORM*****

PATIENT INFORMATION

Arrival Date:		Estimated # 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	
Is the patient currently hospitalized?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Will the patient be receiving outpatient treatment or tests?			<input type="checkbox"/> Yes <input type="checkbox"/> No	

DIAGNOSIS/DEPARTMENT/ INFORMATION

Diagnosis/Reason for Medical Care/Hospital Department (select one)

<input type="checkbox"/>	Bariatric Surgery	<input type="checkbox"/>	Dentistry	<input type="checkbox"/>	ICUs (MICU, SICU, CTICU, NSICU)	<input type="checkbox"/>	Radiation Oncology \$_____
<input type="checkbox"/>	BMT/Car-T/Stem Cell	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	Neurology-related	<input type="checkbox"/>	Trauma: GSW___MVA___
<input type="checkbox"/>	Burn Treatment	<input type="checkbox"/>	GI Procedure	<input type="checkbox"/>	Orthopedics	<input type="checkbox"/>	THRIVE Program
<input type="checkbox"/>	Cancer (Surgery/Treatment)	<input type="checkbox"/>	Kidney Transplant	<input type="checkbox"/>	Other: _____ Department _____ Diagnosis	<input type="checkbox"/>	Urology
<input type="checkbox"/>	Cardiology-related treatment	<input type="checkbox"/>	Liver Transplant	<input type="checkbox"/>	Perinatal Psychiatry	<input type="checkbox"/>	
<input type="checkbox"/>	Dermatology	<input type="checkbox"/>	Lung Transplant	<input type="checkbox"/>	Pulmonary	<input type="checkbox"/>	

GUEST INFORMATION

Standard Rooms accommodate up to three (3) people. Pine rooms up to four (4). 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/s (if different from patient's)	Relationship to Patient	Cell Phone Number
1.		
2.		
3.		
4.		

HOSPITAL INFORMATION - REQUIRED

*******Incomplete or illegible forms will be returned*******

Name and Title of Staff Completing this Form

Phone No.	Pager No.	Fax No.
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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)
admissions@secufamilyhouse.org

SECU STAFF ONLY:

Volunteer/Staff Name: _____ Date Processed: _____ Done: Phone Call Letter Sent Email

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