



ST. LOUIS HavenHouse

Phone: 314.434.5858 Fax: 314.434.6541
www.havenhousestl.org

HOSPITAL REFERRAL

Please fax this completed form to HavenHouse St. Louis

Check-in Date:

Check-out Date:

PATIENT INFORMATION

Patient Name:

Patient D.O.B.

Guardian Name (N/A, if self):

Address:

City:

State:

Zip:

Phone Number:

Alt. Phone Number:

Additional Patient Information:

Hospital:

Doctor:

Patient Department:

Person Referring:

Phone Number:

PAYMENT INFORMATION

Who is responsible for daily fee? Check one and fill out.

Family (Self-pay)

Hospital: _____

Other: _____

Additional Information:

LIST ALL INDIVIDUALS STAYING IN THE ROOM

One must be 21 years or older

Name	Relationship to Patient	Age

Can all guests use **stairs**?

YES

NO

Need **shuttle** to and from hospital?

YES

NO

Need **dinner** night of arrival?

YES

NO

Upgrade to **TV Room?** (Additional Charge)

YES

NO

Other Guest Needs:

OFFICE USE ONLY