

FISHER HOUSE REFERRAL FORM

Instructions: Patient's families for whom Fisher House services are appropriate, may be identified by a Healthcare Provider, Social Worker, Case Manager, Hospital Ward, Chaplains - DDEAMC or the American Red Cross-DDEAMC at the medical facility.
 See enrollment criteria procedure at the following website: www.ddeamc.amedd.army.mil/visitor/fisher.htm

PATIENT INFORMATION

Patient Name: _____ Ward/Room: _____ Ward/Room Phone #: _____
 (Last Name, First Name)

Grade or Sponsor's Grade _____ SSN(Last 4Numbers): _____ Estimated Length of Stay: _____

BRANCH OF SERVICE

AIR FORCE ARMY COAST GUARD MARINES NAVY

CURRENT STATUS

ACTIVE DUTY NATIONAL GUARD RESERVE RETIREE VETERAN

LODGING REQUEST INFORMATION

NARRATIVE (Circumstances validating the need for lodging. Use as many lines as needed and or attach other paperwork)

Check all that apply: I = VSI/SI II = Life Threatening Surgery/Illness III = Patient Undergoing Treatment/Evaluation
 IV = No Friends/Family in Local Area

OIF/OEF: Yes No Air Evac: Yes No Distance traveled (> 40 Miles) Yes No Family has transportation: Yes No

Funded Orders (Military travel orders, Military ITO, or eligible for lodging reimbursement): Yes No

Hardship or other assistance needed: Yes No if yes, also refer to Chaplains, AER, Red Cross, ACS

Fill out the number of guest(s) and Names of Patient's caregiver seeking lodging at the Fisher House:

(Name)	(Relationship to patient)	(Age if under 21)
1.		
2.		
3.		
4.		

Home Address: _____ Phone number where guest can be contacted: _____

Location where guest are staying: _____

Do guest(s) have any special needs: _____

REFERRED BY Health Care Provider, Social Worker, Case Manager, Hospital Ward, American Red Cross – DDEAMC, Chaplains – DDEAMC

NAME (First): _____ (Last Name): _____ Location: _____

Job Title: _____ Phone Number: _____ Email: _____

Signature: _____ Date (mm/dd/yyyy): _____