HAVENHOUSE ST. LOUIS

HOSPITAL REFERRAL

REFERRING OFFICE INFORMATION

Hospital: _____

Doctor: _____

Patient Department: _____

Person Referring: _____

Phone Number: _____

PATIENT INFORMATION

Check In Date	_____	**Check Out Date**	_____
Patient Name:		Patient DOB:	
Mailing Address: City, State ZIP: Country:			
Reservation Contact Name:			
Reservation Contact Phone:			
Relationship to Patient:			
Alt. Phone Number:			
Additional Patient Information:			

PAYMENT INFORMATION

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

◯ Self-Pay (Family) ◯ Hospital: _____ ◯ Other: _____

RESERVATION GUEST(S): List all planning to stay HavenHouse during the reservation	At least one (1) guest must be 21 years or older. All guests 18+ are subject to a required criminal history screening.	
First, Middle and Last Name	Date of Birth	Relation to Patient

To confirm medical need, form is to be completed by medical professional and returned to **fax (314) 434-6541** or **email to reservations@havenhousestl.org**.