Referral Form

Phone: 513.618.5585 Fax: 513.618.5586

Patient Name: ____ Birthdate: ________-________-_________
Month Day Year

Home Address: ____
Street City State Zip

Ohio County: _______________ Country: __________________________

Home Phone: ( ) ______- ___________ Cell Phone: ( ) ______-____________

Email Address:_____________________________________

Patient is

Independent in self-care or needs minor assistance from caregiver

Special Needs

Requires ADA Room Requires TTY Room Requires Service Animal
Uses Adaptive Equipment
Wheelchair Walker Cane TTY
Other: (Please specify) ______________________

Patient Employed By: _____________________________________ Active Retired

Diagnosis: ____

Treatment: Chemotherapy Radiation Surgery BMT
Type of BMT: ______
Other (please specify) ________________________

Referral By: ______________________Title: ____________________ Phone #: ____________

Cincinnati Hospital: __________ Cincinnati Physician: ______________________ Phone #: _______________

Hometown Physician: __________________________________ Phone #: ______________________

____ ______________________
Name of caregiver staying with patient Relationship to patient

Caregiver meets criteria for caregiver at Hope Lodge
Caregiver is able to fulfill role of caregiver at Hope Lodge

Check-In Date* ________________ Check-Out Date*_____________

*Note: It is the responsibility of the referring professional to notify the Hope Lodge director in advance if the check-out date changes.

Healthcare Provider Certification: I acknowledge that I have reviewed the guidelines and rules of the Hope Lodge and certify that to the best of my knowledge, this patient and caregiver meet those requirements.

Signature of referring professional: __________________________ Date: ________________