

Casa Esperanza Room Request Form

Date: _____, 2010.

Former Resident: Yes ___ No ___

Patient's Name: _____ D.O.B _____

SSN: _____

Mother's Info: _____ D.O.B. _____ SSN: _____

Address: _____ City, State: _____

County: _____ Phone Number: (_____) _____

Caregiver's name: _____ Relationship to patient: _____

Message/Cell Phone Number: _____ Number of People: _____

Cancer: _____ Non-Cancer: _____ Condition (if non-cancer) _____

Doctor: _____ Doctor's phone # _____ Hospital: _____

Payment/Referral Information

Referral made by: _____ at _____ Phone _____

Fee quoted: Room Rate \$49.61 _____ Dep. \$15 _____ Handicap Room _____

Self Pay: \$30.00/Small Room _____ \$35.00/Suite _____ Other _____

Payment authorized by: _____ at _____

Dates of Auth: _____ to _____ Auth Number: _____

Referral taken by _____ Date: _____ Time: _____

Estimated date of arrival: _____ Estimated date of departure: _____

Notes: _____

REMINDER: Advise Social Workers and patients that if they do not arrive by 4:00 p.m., their room will be given to patients on the waiting list.