The Midnight Mission

1914~2014

step into the light™

12:01 this is the day™

Hospital to Homeless Service Provider Agency Referral Form

Hospital Information

Referring Hospital Name___________________________________

Referring Hospital Staff Name: ______________________________ **Dept:** ______________________

Phone Number: ______________ **Fax Number:** _______________

Receiving Facility Information

Receiving Facility Name: ________________________________ **Fax Number:** ___________________

Receiving Facility Address: ____

Receiving Staff Person Name: _____________________________ **Phone Number:** ________________

Confirmation Number (If applicable): ____________________

Service Provider's Signature of Acceptance: ____

Patient Information

Client Last Name: _________________________________**Client First Name:** ___________________

Last Known Address: ___________________________________ **City/St/Zip:** ____________________

Age (If Available): ______________ **Gender (Male/Female):** ___________

Emergency Contact Information (If Available):

Name: ___________________________________ **Relationship:** ________________________

Telephone: _______________________________

Does the client have special dietary needs? (Yes/No) _________

If yes, please describe: ____

Is the client ambulatory? (Yes/No) __________

If no, please describe: ____

Does the client have a copy of his/her discharge plan? (Yes / No) _________

Expected Date / Time of Client Arrival: _________________________

Has the client agreed to be transported to named facility? (Yes/No) ________

Client Signature: ____ **Date:** _____________

Hospital Staff Signature: _____________________________________ **Date:** _____________