JoeAnna's House Referral Form

321 Royal Avenue Kelowna, BC V1Y 0G4
Phone: (250) 470-0100 Fax: (250) 470-0102
Email: info@joeannashouse.com

Please review admission information prior to submitting this form.

PATIENT Information

Last name: _____ First Name: _____ Middle Initial: _____

Home Address: _____ City: _____ Postal Code: _____

Birth Date: _____ Phone: _____ Email: _____

Referral Source / Social Worker: _____ Phone: _____

Reason for Admission: _____ Relationship to Guest _____

NICU ☐ MATERNITY ☐ PEDIATRICS ☐ ADOLESCENT PSYCHIATRY ☐ ICU ☐ CARDIAC ☐

EMERGENCY TRAUMA ☐ NEUROLOGY ☐ RESPIRATORY ☐ ORTHOPEDICS ☐

ADULT PSYCHIATRY ☐ OTHER _____ WARD _____

Date of Admission: _____ **Anticipated Discharge Date:** _____

GUEST Information

Last name: _____ First Name: _____ Middle Initial: _____

Home Address: _____ City: _____ Postal Code: _____

Birth Date: _____ Phone: _____ Email: _____

Guests: # of Adults: _____ # of Children: _____ Ages: ____, ____, ____, ____ # of Beds Requested: _____

First and Last Names of all Adult Guests:

_____

*** One Guest must be over the age of 19. Proof of age and photo identification for all adults is required.**

Special Requirements: Wheelchair/Mobility Needs ☐ BC Certified Service Dog ☐ Other ☐ _____

Notes

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Date Rec'd: _____ Entered into HouseMate: _____ Date Contacted IH: _____