FOR OFFICIAL USE ONLY

COMMANDER, NAVY INSTALLATIONS COMMAND
NAVY & MARINE CORPS FISHER HOUSE
REFERRAL FORM

A referral does not guarantee or reserve space in a Navy & Marine Corps Fisher House.

Naval Medical Center San Diego Fisher House Office Hours:
Mon-Fri: 8 a.m. to 4 p.m.; closed on weekends and federal holidays
Phone: (619) 532-8751/9055, Fax: (619) 532-5216

REFERRAL PROCEDURES

(a) The referral form must be prepared and signed by a case manager, social worker, medical provider or military liaison.
(b) Referral forms may not be filled out as a self-referral; they must be completed by one of the above noted in item (a).
(c) An advance referral form may be completed and submitted prior to the family's arrival, but does not guarantee availability.
(d) Families may not always be admitted on the first request. Admittance is based on Fisher House availability.
(e) One room per family/referral
(f) One parking space per room

Referral forms must be sent directly via fax to: (619) 532-5216 or via email to: sandiegofisherhouse@outlook.com.

Admittance Process and Guidelines

(a) Families will be contacted by the Fisher House staff, who will advise them of acceptance of the referral and an available move-in date.
(b) Patients/outpatients are required to have a caregiver during their stay.
(c) Families arriving on funded orders are authorized a maximum length of stay of five nights.
(d) Families not receiving financial assistance have priority.
(e) Families may be admitted after the normal business hours of 8 a.m. to 4 p.m. if prior arrangements have been made.
(f) Emergency or overnight walk-ins cannot be accommodated.
(g) General house rules and guidelines are covered at the time of check-in and guests are required to comply with all Fisher House rules.

REQUESTED LODGING DATES

ARRIVAL DATE: ______/______/______ ESTIMATED DEPARTURE DATE: ______/______/______

FUNDED ORDERS: ☐ Yes ☐ No

GUEST INFORMATION (REQUIRED)

Name: Relationship to Patient:

1. ________________________________ ________________________________
2. ________________________________ ________________________________
3. ________________________________ ________________________________

Will there be a service dog during this stay? ☐ Yes ☐ No

Home Address: ________________________________ Email Address: ________________________________

City: ________________________________ Home Phone:_____/_____/_____ Cell:_____/_____/_____

State:__________ Zip:__________ Work Phone:_____/_____/_____

Vehicle Make: ________________________________ Vehicle License Plate: ________________________________

PATIENT INFORMATION

Name: ________________________________ Estimated Hospital Stay (# of days): ______________

Patient Location (ward/floor):______________________ Room/Bed: ________________________________

In-patient: ☐ Yes ☐ No

Individuals receiving the following medical treatments are not eligible for admittance as a resident of the Fisher House: home health nursing required; wound V.A.C. Therapy System units; Clostridium difficile (C- Diff.); Vancomycin-resistant Enterococcus (VRE); total parenteral nutrition (TPN); running intravenous fluid drip (IVs).

SPONSOR INFORMATION

Name:_______________________________________ Pay Grade:______________________________

Branch of Service: ☐ Navy ☐ Marine Corps ☐ Air Force ☐ Army ☐ Coast Guard

Status: ☐ Active Duty/Duty Station:_____________________________ ☐ Retired Military ☐ Veteran

HOSPITAL POINT OF CONTACT

Name of person filling out referral (print): ____

Title (Case Mgr/Social Worker):_____________________________ Signature/Date: ____________________

Phone Number:_____/_____/_____ Email address: ____

SPECIAL NOTES

This authorization for release of the above information to the above named persons/organizations will expire on:___________

I understand that:

a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the Fisher House manager if this is an authorization for information possessed by the military treatment facility. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.

b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR 164.524.

I request and authorize the named provider/treatment facility/TRICARE health plan to release the information described above to the named individual/organization indicated.

The Fisher House accommodates families who need to be close to loved ones undergoing treatment as an inpatient at any medical treatment facility.

The Fisher House is available for a period not to exceed 30 days to families who have no local accommodations. The Fisher House serves as a compassionate and supportive home for families who are coping with the stress of a life-threatening crisis. The Fisher House is not a step-down nursing medical facility and may not be treated as such.

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), this notice informs you of the purpose of the form and how it will be used. Please read it carefully.

AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R: SORN DPR 40 DoD.

PRINCIPAL PURPOSE(s): The purpose of this form is to allow the DON (CNIC) Fisher House managers to determine eligibility and priority for lodging at the Fisher House based on the criteria and eligibility as set forth in SECNAVINST 7010.8B.

ROUTINE USE(s): The routine use is to allow the DON (CNIC) Fisher House managers to determine continued eligibility based on routinely updated medical status to allow for further lodging within the Fisher House.

DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the disapproval of lodging at the DON Fisher House.

This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.