



REQUEST FOR TEMPORARY HOUSING

Kathy's House
600 N. 103rd Street
Milwaukee, WI 53226
414-453-8290

Fax: 414-453-8292

After this form is faxed to Kathy's House, the guest must call Kathy's House.
No guest will be admitted without this referral
AND telephone contact with Kathy's House.

Health Care Provider

Name of person completing form _____ Position _____
Hospital _____ Phone _____ FAX _____ Date _____
Milwaukee hospital's attending doctor _____ MD Contact # _____

Patient Information

Name _____ City/State _____ Cell Phone # _____

Guest Information

*Guests must reside at a permanent address 50 miles or greater from Milwaukee

Name _____ City/State _____ Cell Phone # _____

Requested Arrival Date _____ Length of Stay _____ Total # of Guests _____

Who will be staying at Kathy's House? Patient Guest(s) Both

Will the patient require a caregiver? Yes No Please explain needs: (Note caregivers must be at least 18 years old)

Has any guest been exposed to an infectious or contagious disease? Yes No

Will transportation to hospital be needed? Yes No Anticipated Frequency? _____

What is the patient's diagnosis? _____

What is the treatment protocol? _____

Are there any patient concerns and/or family challenges that the staff at Kathy's House should be aware of? Yes No Please explain:

Have you ever stayed at Kathy's House in the past? Yes No If so, when? _____

I request temporary housing at Kathy's House and authorize the release of the following information by hospital personnel to Kathy's House.

(Patient/Authorized Signature)

PLEASE NOTE: CHECK-IN TIME IS NO LATER THAN 4:30 PM Mon-Fri and 3:30 PM Sat-Sun

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