Commander, Navy Installations Command
NAVY & MARINE CORPS

Fisher House Program

GUEST REFERRAL FORM

A referral does not guarantee or reserve space in a Navy & Marine Corps Fisher House.
Naval Medical Center Camp Lejeune Fisher House Office Hours:
Monday – Friday: 8:00 a.m. to 4:00 p.m. (closed on weekends and federal holidays)
Phone: (910) 450-3885 / After-Hours Duty Phone: (910) 750-5845 / Fax: (910) 450-3887
Email: info@lejeunefisherhouse.org

REFERRAL PROCEDURES

- **(A)** Referral forms must be prepared and signed by a case manager, social worker, medical provider or military liaison. They may not be filled out as a self-referral.
- **(B)** An advance referral form may be completed and submitted prior to the family's arrival, but does not guarantee availability.
- **(C)** Families may not always be admitted on the first request. Admittance is based on Fisher House availability.
- **(D)** One room is provided per family per referral and one parking space is provided per room.
- **(E)** Referral forms must be sent directly via fax or email to the contact information provided above.

ADMITTANCE PROCESS AND GUIDELINES

- **(A)** Families will be contacted by the Fisher House staff advising 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 may be admitted after the normal business hours of 8 a.m. to 4 p.m. if prior arrangements have been made.
- **(D)** Emergency or overnight walk-ins may be accommodated after contacting the House manager.
- **(E)** General Fisher House rules and guidelines are covered at the time of check-in and guests are required to comply.

LODGING INFORMATION

Is Restriction of Movement (ROM) lodging required? ☐ Yes ☐ No

If YES, have arrangements been made at the Navy Lodge, NGIS or Inns of the Corps? ☐ Yes ☐ No

ROM will end on _____ and referral will be forwarded to Fisher House to continue lodging.

Arrival Date:_____ Estimated Departure Date:_____

For Active Duty, is guest on orders? ☐ Yes ☐ No What type?_____

GUEST INFORMATION (REQUIRED)

Name: Relationship to Patient:

1._____ _____

2._____ _____

3._____ _____

4._____ _____

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

Home Address:_____ Email:_____

City:_____ Home Phone:_____ Cell:_____

State:_____ Zip:_____ Work Phone:_____

Vehicle Make/Model:_____ 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 (e.g. Social Worker):_____ Signature/Date_____

Phone:_____ Email:_____

This authorization for release of the above information to the above named persons/organizations expires 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.

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.