**Green Gables Guest House Registration Checklist**

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|  Year\_\_\_\_\_\_\_\_\_  |
| 🞎 New Guest 🞎 Yes FOLDER MAILED date \_\_\_\_\_ 🞎­ TOo LATE To Mail🞎 Past Guest 🞎 Yes info emailed date \_\_\_\_\_\_🞎 Guest IN WHEELCHAIR, If Checked: *Make Sure room #1 is Available* |
| **GUEST HOUSE DOES NOT ASSIST** |  |
| **WITH DAILY LIVING TASKS** |  |
| **PATIENT NAME:** |  |
| *PHYSICIAN NAME:* |  |
| Phone#: |  |
| street address: |  |
| city/state/zip |  |
| E-Mail Address |  |
| GUEST #1 NAME: |  |
| GUEST #1 STATUS: | 🞎 *Patient* 🞏 *Spouse/Family Mbr.* 🞏 *Friend* |
| GUEST #2 NAME: |  |
| GUEST #2 STATUS: | 🞏 *Patien* 🞏 *Patient* 🞏 *Spouse/Family Mbr.* 🞏 *Friend* |
| ARRIVAL DATE: |  |
| ANTICIPATED DEPARTURE DATE: |  |
| **FEE AGREED UPON: $25.00** |   |
| PARKING PASS NEEDED? 🞏YES 🞏 NO | ABLE TO DO STAIRS 🞏 YES 🞏 NO  |
| GUEST TO PICK UP KEYS AT: |  🞏 Main Hospital Desk 🞏 Other: |
| **SCREENING: MARK ALL BOXES THAT APPLY** |
| CANCER TREATMENT: 🞏 Radiation Therapy 🞏 Day Txt 🞏 Ca. Rehab 🞏 Surgery 🞏 Lymphedema 🞏 Diagnostic 🞏 ABMT (Transplant) 🞏Ca. Other 🞏Day Guest \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Kern Critical Care / ICC / CCU 🞏Rehab/RIO 🞏Bariatric/Obesity Clinic🞏 Transplant (Kidney, etc..) 🞏 Devers 🞏EHHC patient🞏 Other:\_ 🞏 Other Medical/Surgical \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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