



**Fort Campbell Fisher House**

652 Joel Dr  
 Ft. Campbell, KY 42223  
 Office (270) 798-8330  
 Fax (270) 798-8804  
 Office Hours 900-1600 M-F  
 Closed weekends & federal holidays  
 www.fortcampbellfisherhouse.org  
 www.facebook.com/KYFisherHouse

**Basic Eligibility Requirements**

Patient must be a service member, retiree, veteran or a dependent, and actively receiving treatment or hospitalized in local area for injuries/wounds/illnesses.

Referrals for same day check-in should be received by 3pm. Without prior arrangements, only emergencies will be checked in outside of office hours.

Out-Patient stays are case by case at the manager's discretion. It is advised that all patients be escorted by a loved one in case of emergency.

Potential guests must be free of contagious illnesses or infections.

Referrals are NOT a reservation. Except in special circumstances, room availability is not confirmed until the day prior to scheduled check-in.

If referral is approved but rooms are limited, the Fisher House Manager will prioritize based on medical need and others will be placed on waiting list.

wendy.j.carlston.naf@mail.mil

**REFERRED BY:**

Phone: \_\_\_\_\_

Date: \_\_\_\_\_

Case Mgr  AW2  Social Work

Med Staff  Unit Rep  Other

Self (permitted for previous guests only). Date of last visit: \_\_\_\_\_

# Fisher House Referral Form

## PATIENT INFORMATION

Name: _____		DOB: _____	
Status: SI/VSI <input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient <input type="checkbox"/>		Service Member <input type="checkbox"/> Family Member <input type="checkbox"/>	
Briefly explain medical situation: _____		BACH Ward: _____	
Treating Physician: _____		Other Facility: _____	
If Medevac, status: BI <input type="checkbox"/> NBI <input type="checkbox"/> D <input type="checkbox"/>			

## GUEST INFORMATION

List everyone that will be staying in the Fisher House, including the patient if applicable.

Room preference: <i>bed size &amp; (occupancy)</i> Subject to availability. Doubles reserved for min of 3.	<input type="checkbox"/> 1-queen (1-3 occupants) <input type="checkbox"/> 2-doubles (3-4) <input type="checkbox"/> 2-twins (1-3) 3rd occupant in queen/twins sleeps on an air mattress or recliner. We have a limited # of portable cribs and tot cots.		
Names	Relationship to patient (include ages for anyone under 18)	Phone #	
1. _____	_____	_____	
2. _____	_____	_____	
3. _____	_____	_____	
4. _____	_____	_____	
Home/Primary Address: _____			
Has anyone experienced a recent contagious illness?		If yes, what?	
<input type="checkbox"/> yes <input type="checkbox"/> no		_____	
Family members have military IDs?	<input type="checkbox"/> yes <input type="checkbox"/> no	Expected date of arrival?	
Family is on funded orders (i.e.: ITO, TDRL, TDY, etc...)	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	
Family will have vehicle while here?	<input type="checkbox"/> yes <input type="checkbox"/> no	Projected length of stay?	
_____			
Any special needs or considerations we need to be aware of?			
_____			

## MILITARY SPONSOR INFORMATION

Name (if different from patient): _____	Rank: _____	SSN Last 4: _____
Barracks _____	On Post _____	Off Post _____
Address: _____		Phone: _____
Email: _____		Duty Phone: _____
Military Branch _____		Status/Component _____
_____		Originating Unit &/or DutyStation: _____

## OFFICE USE ONLY

### APPROVED BY:

Check-In Via: in person  SELF  Unit POC

Check-In \_\_\_\_/\_\_\_\_/\_\_\_\_

Check-Out \_\_\_\_/\_\_\_\_/\_\_\_\_

Room # \_\_\_\_\_