The Mark Preece Family House

191 Barton St E
Hamilton, ON L8L 2W7

MEDICAL REFERRAL FORM

(To be completed by medical referer)

Guest Family Information

Date of referral:	Date room is needed:
Guest name:	
Address:	City & Postal Code:
Phone number:	Email address:
Number of people requiring accommodation:	
Name(s) of additional guests:	

Patient Information

Patient's Name:
Ward patient is being admitted to:
Estimated length of stay:

Medical Referral Made by

Name:	Profession/ Title:
Hospital:	
Contact number:	Email:
Notes: *(please indicate priority, any special guest requirements or circumstances, etc)*	
Signature:	

CONSENT TO SHARE INFORMATION

I authorize _____ *(name of hospital/clinic that is referring the family)* to provide the Mark Preece Family House with the above information and to confirm that the above mentioned patient is being admitted to_____ *(name of the Hamilton hospital that patient is being admitted to*).

_____ _____

Guest Signature *Date*

- Cost to stay is $60 per room per night (Visa, MC, debit, cash or cheque accepted)
- Free parking is provided on location

Please fax the completed Guest Referral Form to: 905-529-9955
If you have any questions please call us at 905-529-0770