To: ____Editha House_____

Address: 336 E. Willetta St, Phoenix, AZ 85004

Fax: ___602-532-7062_____

Phone: _602-388-4920_____

From: _____

*IMPORTANT:
Call to confirm fax was received.

Please call 602-388-4920 with questions.

Room type based on availability.
Maximum 2 adults per room.

Patient must travel 40 or more miles to the treatment facility.

There is a three (3) night minimum stay required.

Check-in is by appointment only between 8:00 am - 8:00 pm. Upon arrival, guest and caregiver must supply Editha House with a government-issued photo ID (State ID, Driver's License, VA Card, etc.) for admittance.

To be completed by Referring Agent. All information must be filled out. PLEASE PRINT CLEARLY.

Referring Agent:_____Title:_____

Phone:_____Date of Referral:_____ Medical Facility:_____
As the referring source, I have reviewed the attached "Eligibility Requirements" with the patient and caregiver.

I agree with the above statement. Signature: _____
Signature of Referring Agent

Patient Information:

Name:_____ DOB: _____/_____/_____

Address:_____ City:_____ State:_____ Zip: _____

Male/Female:_____ Home Phone: (____)_____ Cell Phone: (____)_____

Miles from Residence to Treatment Facility:_____ Email:_____

Diagnosis:_____ Treatment:_____

Name of Employer:_____

Are there any additional medical problems that may affect the patient's condition while staying at Editha House? (Please attach additional information if needed.)_____
_____

Please circle one:
Patient speaks and/or understands English? **YES / NO**
Patient has an infectious disease or infectious disease symptoms? **YES / NO**
Patient has been convicted of a violent crime, domestic violence, crime against a child, theft, and/or illegal drugs? **YES / NO**
Patient is on probation or parole? **YES / NO**
Patient has sought a civil order of protection? **YES / NO (If yes, what were the details? Please attach explanation)**
Patient has ever sought a civil order of protection? **YES / NO (If yes, what were the details? Please attach explanation)**

Has the patient been required to register on the state or National Sex Offender Registry? **YES / N0**
Is the patient a smoker? **YES / N0**

Treatment Start Date:_____ **Treatment End Date:**_____

Estimated Time of Arrival:_____

Treatment Facility:_____

Address:_____ City:_____ State:_____ Zip: _____

Patient's Doctor:_____

Phone: _____ Fax:_____ Email:_____

Address:_____ City:_____ State:_____ Zip: _____

Caregiver Information:

Caregiver Name: _____ DOB:_____/_____/_____

Address:_____ City:_____ State:_____ Zip: _____

Male/Female:_____ Home Phone: (_____)_____ Cell Phone: (_____)_____

Relationship to Guest:_____

Name of Employer:_____

Please circle one:
Caregiver speaks and/or understands English? **YES / N0**
Caregiver has an infectious disease or infectious disease symptoms? **YES / N0**
Caregiver has been convicted of a violent crime, domestic violence, crime against a child, theft and/or illegal drugs? **YES / N0**
Caregiver is on probation or parole? **YES / N0**
Caregiver has ever sought a civil protection? **YES / N0**
Has a civil order of protection ever been sought against caregiver? **YES / N0 (If yes, please what were the details? Please attach explanation)**
Has the caregiver been required to register on the state or National Sex Offender Registry? **YES / N0**
Is the caregiver a smoker? **YES / N0**

**Please allow up to 20 minutes for check-in and check-out.

Editha House accepts all guests during the time that they are receiving active treatment. All individuals who meet the eligibility requirements are welcomed at Editha House, when room is available; regardless of race, creed, citizenship, disability, gender, gender identity, color, ethnicity, heritage, veteran status, economic status, or sexual orientation.