Texas Children's Hospital®

ROOM REQUEST FORM

SEND TO		SENT FROM		
	(Send Fax to 2 checked areas) √ Room Management Fax - 832-825-5506 √ Admissions Fax - 832-825-5887 Room Management Tel. 832-824-5777 Admissions Tel - 832-824-5500		Name	
			Address	
			Phone	

Date of expected Admission:		Date Request Sent:	
Date of expected Surgery:		Date Request Received:	

Patient Information

Patient Name:		Patient DOB:	
Has the patient been to TCH before? Yes No		Medical Record Number:	
Patient Home Telephone:		Cell:	

Admission Information

Primary Diagnosis:

Secondary/Other Diagnosis:

Admission Type- Circle One

Urgent Elective

Patient Class - Circle One

Inpatient Surgery Admit Same Day Surgery Observation Outpatient in a bed/Infusion

Bed Type - Circle One

Special Care Intermediate/Intensive Acute Care Other

Admit Source - Circle One

Clinic or Physicians office Other:

Physician Information

Admitting Physician:	Contact Name & Telephone:	
Attending Physician:	Contact Name & Telephone:	
Referring Physician:	Contact Name & Telephone:	
Primary Care Physician:	Contact Name & Telephone:	

Room Information

Treatment Plan:			
Estimated Length of Stay:		Contact Name & Telephone if additional information is needed:	

Special room or equipment Needed - Circle

Tracheostomy BiPap/Cpap/Vent Wheelchair Other:

Isolation Needed - Circle

Airborne Contact Droplet MRSA Special Consideration: