Hope House Reservation Request Form
Houston's First Baptist Church

Date rcvd in Office:_____

**Check in and out for Hope House Guests is done during Pastoral Care office hours---
Monday through Friday, 8:00 am to 5:00 pm. Weekends are reserved for family and worship. **

Patient's Name: _____

Dates Requested for Stay:

Arrival _____ Departure _____ Length of Stay _____ Days

********Requested Dates are subject to approval and availability. There is a minimum stay of two weeks.***

PLEASE INCLUDE A PHOTO OF PATIENT AND SPOUSE OR CAREGIVER

Email Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

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

Date of Birth: _____

HFBC Contact:_____

How did you hear about the Hope House? _____

Brief description of diagnosis:_____

Church Membership: _____

Senior Pastor's Name: _____ Church Phone: _____

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

Hospital of Treatment: _____ Patient ID: _____

Name of Social Worker: _____ Phone: _____

Primary Doctor: _____ Phone: _____

Primary Caregiver Staying with Patient: (This person will serve as the Houston Emergency Contact.)
Criminal Background check required (Please submit completed Waiver Form)

Name:_____ Relation: _____ Cell #: _____

Address: *(If different than Patient)* _____ City: _____ State: _____ Zip: _____

Email Address: _____

Additional Caregivers/Guests Staying with Patient: **Criminal Background check required (Please submit completed Waiver Form)**

Name:_____ Relation: _____ Cell #:_____ Email:_____

Name:_____ Relation: _____ Cell #: _____ Email:_____

Name:_____ Relation: _____ Cell #: _____ Email: _____

Emergency Contact: (Other than a local caregiver---someone at home)

Name:_____ Relation: _____ Cell #: _____ Email: _____