



CAMP LEJEUNE FISHER HOUSE REFERRAL FORM

4 Recovery Way, Camp Lejeune, NC 28547 • (910) 450-3885

Office Hours: Mon – Fri, 0800 – 1600 closed Federal Holidays

Referrals may be emailed to camplejeunefisherhouse@us.navy.mil.

Referral forms require preparation and signature by a case manager, social worker, medical provider or military liaison. Self-referrals are not accepted. Referrals may be submitted prior to guest arrival but do not guarantee availability. If local accommodation is unavailable, and the guest meets eligibility requirements, Fisher House may provide lodging. One room is allocated per family per referral along with one parking space.

Guests will be contacted by a Fisher House staff member advising them of referral acceptance and an available check-in date. Guests may be admitted after normal office hours if prior arrangements have been made. Emergency or after-hours walk-in guests may be accommodated on the next business day based on availability. Patients (including outpatients) are required to have an adult caregiver (18+) during their stay. Fisher House is not a step-down nursing or medical facility and may not be used or treated as such.

GUEST INFORMATION <i>(list everyone for whom lodging is requested)</i>		
Requested Arrival Date:	Estimated Departure Date:	
Primary Guest Name:	Relationship to Patient:	
Mailing Address/City/State/Zip:	Primary Phone:	Secondary Phone:
Email Address:	Vehicle Make/Model:	Vehicle License Plate:
Service dogs are welcome, however, according to federal regulations, emotional support animals and pets are not allowed.		Will there be a service dog in use during this stay? ☐ YES ☐ NO
Additional Guest Names:		Relationship to Patient (age if minor):
2.		
3.		
4.		
PATIENT INFORMATION		
Name:	Est. # of Days in Hospital:	Patient Status: ☐ IN ☐ OUT
Hospital/Medical Facility:	Ward/Department/Section:	
SPONSOR INFORMATION <i>(family member with active duty, veteran, or retiree status)</i>		
Sponsor Name:	Pay Grade:	Patient Travel Status: ☐ PCS ☐ TDY ☐ N/A
Branch of Service: ☐ AF ☐ ARMY ☐ CG ☐ MC ☐ NAVY ☐ SPACE FORCE ☐ OTHER (list affiliation):	Status: ☐ AD/STATION: _____ ☐ RET ☐ VET ☐ OTHER (list affiliation):	
REFERRED BY <i>(verifying patient is actively receiving treatment as described)</i>		
Printed Name:	Title/Role:	
Signature:	Phone:	Email Address:
NOTES <i>(list any special circumstances or requests)</i>		
PRIVACY STATEMENT		
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R: SORN DPR 40 DoD. PRINCIPAL PURPOSE(s): The purpose of this form is to allow the DON (CNIC) Fisher House managers to determine eligibility and priority for lodging at the Fisher House based on the criteria and eligibility as set forth in SECNAVINST 7010.8c. ROUTINE USE(s): The routine use is to allow the DON (CNIC) Fisher House managers to determine continued eligibility based on routinely updated medical status to allow for further lodging within the Fisher House. DISCLOSURE: Voluntary; Failure to complete and sign the referral form may result in the disapproval of lodging at a DON Fisher House.		

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