The Comfort House
A Home Away From Home

317 Telfair Street
Augusta, GA 30901

706-774-9012

Comforthouseofaugusta@gmail.com

Today's Date_____

To Be Completed by Hospital Support Staff

Guest Name (Full Name) _____

Home Address_____

City_____ State_____ Zip code_____

Cell Phone_____ Email_____

Patient's Name (Full Name) _____

Hospital _____Unit Name _____

Treatment Start Date_____ Check one: _____In-Patient _____Out-Patient

Length of Stay Required: _____Days _____Weeks

Please advise referred guests that comfort House accommodations are on a first come first serve basis.

Number of Guests Needing Accommodations_____

Additional Guest #1_____ Additional Guest #2_____

Any Special Accommodations Required_____

*****First floor rooms are limited; Guests must be able to climb stairs to access second floor rooms*****

Date of Arrival _____**Guests call 706-774-9012 to set up check-in date & time prior to arrival.**

Referrer Name_____Title_____

Phone_____ Email_____

Completed forms should be submitted by email with "Guest Referral" in the subject line.
After submitting the referral, please call for faster processing of the request.