



Ronald McDonald House Charities*
 3402 Fort Worth St. , Corpus Christi, TX 78411
 361.854.4073 tel 361.854.9174 fax

www.corpuschristirmhc.org

Family Survey

Name: _____ Date: _____

Home Town: _____

1) What did you like most about your stay? _____

2) Was this your first stay at the Ronald McDonald House? YES NO

3) How did we accomodate you during your stay? _____

4) Was your whole (immediate) family together during your stay? YES NO PORTION OF THE TIME

5) Was your patient child: AN INPATIENT AN OUTPATIENT BOTH

6) What was the name of your patient child's disease or condition?
 Cancer Accident/Trauma
 Neonatal/Premature Birth Neurological
 Heart Disease Pulmonary
 Transplant Ophthalmology/Eye Condition
 Orthopedic Other: _____
 Genetic Condition (please tell us)

7) What is your patient child's age? _____

8) What is your relationship to the patient child?
 Mother Grandmother
 Father Grandfather
 Stepmother Other: _____
 Stepfather

9) During your stay, which hospital has been treating your child? _____

10) How long did you stay in the Ronald McDonald House? _____

11) Questions or Comments? _____

12) What is your email address? _____

