HOSPITAL FAX COVER SHEET

Date:________________________

Number of pages:_____________

TO:

PREADMISSION REVIEW PHONE:(Check PSA In Your Area For #'s)
TOLL FREE:
INTAKE/SCREENING PHONE:
PAR FAX NUMBER:

FROM:

Facility Name: ____

Contact Person: ____

Phone Number: ____

Fax Number: ____

Client Name: ____

(PLEASE PRINT CLIENT'S NAME ON EACH PAGE)

REQUESTING:
(Please check one)

_____ PAS-NON-MEDICAID, ASSESSMENT

_____ PAS-NON-MEDICAID,
ASSESSMENT NOT REQUIRED

_____ PAS & LOC - MEDICAID

_____ LOC ONLY - MEDICAID

_____ Other (EXPLAIN BELOW)

Special Instructions:____________________________________

____

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Please check one:

☐ **REFAXING**

Reason:__________________________

☐ **ADDITIONAL INFO. Requested by:**

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