HOSPITAL FAX COVER SHEET

Date: _____

Number of pages: _____

PREADMISSION REVIEW PHONE: _____

PAR FAX NUMBER: _____

FROM: **Facility Name**: _____

Contact Person: _____

Phone Number: _____

Fax Number: _____

Client Name: _____

(Please Print Consumer's Name On Each Page)

REQUESTING:

_____ **PAS Only**

_____ **PAS & LOC**

_____ **LOC ONLY**

_____ **Other (Explain)** _____

REFAXING ADDITIONAL INFO.

Requested by: _____

LTCC Assessment Questions

1. **What is the expected Length of stay and purpose of stay in NF?** _____
2. **Are there supports available to support a return to the community?** _____
3. **Are there any previous NF admissions?** _____
4. **Individuals self report of assets. Will individuals assets be deleted within the next six months? Does the individual have more or less than $30,000?** _____
5. **Is individual or individual's representative open to have an assessment which would address community options and planning for long term needs?** _____