

## 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?** \_\_\_\_\_

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