PREADMIT SHORT FORM

Contact information for the person coordinating the referral:

- Name_____
- Voicemail_____
- Mobile Phone Number_____
- Email_____
- Fax Number_____

Type of bed requesting:

- ICF
- SNF Skilled need_____

  Diagnosis_____
- Disposition_____

Misc.

- Code Status_____
- Allergies_____
- Height and Weight_____
- Smoker ☐Yes ☐No

Other pertinent information

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