HEALTH SYSTEMS

Forensic Residential Treatment Facility Bed Hold Request Form

Provider Name: **Date**:

Client Information:	
Name:	
DOB:	SSN:

Treatment Details:
Date Approved for Admission:
Provider Program Type/ Service Description:
Name of referring facility:
Anticipated Date of Admission:
30-Day Review Status:

[**Please submit all bed hold requests to your network manager and Kayla Walton via fax or encrypted email.**]

Contact Information:			
Agency Representative (Enter Name of Contact Person)	Phone	Fax	Email
LSF Health Systems [Please send all bed hold requests to your network manager]	904-900-1075	904-900-1628	[Please send all bed hold requests to your network manager and Kayla Walton via encrypted email]
Provider Contact			

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Provider Representative Signature LSF Health Systems Signature, **Authorizing *bed hold***