HEALTH SYSTEMS

Bed Hold Request Form

Provider Name: Click here to enter text. **Date**: Click here to enter a date.

Consumer Information:	
Name: Click here to enter text.	
DOB:	SSN:

Treatment Details:
Date of Admission: Click here to enter a date.
Provider Program Type/ Service Description: Click here to enter text.
Name of facility Consumer transferred to: Click here to enter text.
Date leave of absence began: Click here to enter a date.
Reason for Transfer/Leave of absence: Choose an item.
Bed Hold Request for Number of Days: Click here to enter text.

[**Please submit all bed hold requests to your network manager 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 via encrypted email]
Provider Contact Click here to enter text.			
Receiving Facility Click here to enter text.			
Community Case Manger (if applicable) Click here to enter text.			
Parent/Guardian (if applicable) Click here to enter text.			

_____ _____

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