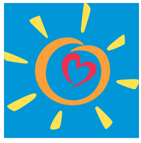

Request for Recuperative Care Extension

INSTRUCTIONS: Please complete form and attach required documents. After completion, you may submit the form via Syntranet or fax **213.536.0634**.

Patient Information

Is patient aware of referral? ☐ Yes ☐ No *(If No, please stop and do not move forward)*

**Please view clean document for reference.*

First Name: ______________________ Last Name: ______________________

CIN: ______________________ Date of Birth: *mm/dd/yyyy* ____/____/________

Admission Date: *mm/dd/yyyy:* ____/____/________

Date of 1st Extension: ____/____/________

Date of 2nd Extension: ____/____/________

Recuperative Care Information

Name of Recuperative Care Facility: ______________________

Contact Person Name: ______________________

Phone Number & E-mail: ______________________

Justification for Continued Stay:

____

____

____

____

Today's Date: mm/dd/yyyy ____/____/________ ☐ Facility Progress Notes included

Disclaimer: Facility progress notes MUST be included. If these forms are not filled out completely or have missing documents, referrals will be returned and will delay the authorization process.