FAX COVER SHEET/ ED TEAM DEBRIEFING FORM

****INTERNAL USE ONLY****

Date:

To:

Phone: **Fax:**

From:

Phone: **Fax:**

Comments:

SPOE CHILD ID#: ____________________
Child Name: ______________________________ DOB: __________ Age: ___________
Intake/Service Coordinator: ____
Lead ED Team Representative: ____

Why would child benefit from services?

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____

After team discussion about the assessment information, who best fits the needs of the child? (Initial recommendations)

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Other information you wish to share with the team prior to meeting:

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Privacy Statement:
This message may contain client health information which is protected according to HIPAA and other state and federal regulations. Only the intended recipient is allowed access to this information.