

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?

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

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

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.