El Paso Children's Hospital

DIRECT ADMISSION FAST PASS

Call AOD at 915.474.8974 for MD: MD consultation.

FAX THIS FORM and demographics to **915.242.8481.**

DATE:_____ /_____ / _____

PATIENT NAME: _____

DOB: _____ **Gender** _____ **CONTACT PHONE #** _____

REFERRING CLINIC & PROVIDER NAME: _____

REFERRING CONTACT & PHONE #: _____

REFERRING CLINIC FAX: _____

ADMITTING DIAGNOSIS: _____

_____

_____

☐ Isolation Precautions

REFERRING PROVIDER SIGNATURE: _____

EPCH ADMITTING PHYSICIANS NAME

☐ SELF_____ ☐ HOSPITALIST _____ ☐ OTHER _____

Provide your patient this form and instruct them to present it to EPCH Main Admissions, (located across the Enchanted Forest) from 7 am - 5:30 pm, or if they arrive after hours they should hand this form to the registrar at the El Paso Children's Hospital ED between 5:30 pm - 7 am.

For Hospital Use Only

STATUS OF ADMISSION

FIN #:

☐ Office representative notified of admission status

Time bed ready _____

Patient admitted to Room #: _____

Admission Support Staff:: _____

DIRECT ADMISSIONS REQUEST

CLINIC PATIENT IDENTIFICATION LABEL

EPCH Fast Pass Map