

REQUEST FOR EXPEDITED
NON-JCAHO RTF SERVICES

1. CLIENT'S NAME _____

2. PROVIDER NAME _____ PHONE: () ____ - ____
(CONTACT PERSON)

3. PRESCRIBER NAME _____ PHONE: () ____ - ____

SERVICE REQUESTED _____ START DATE _____ END DATE _____

REASON FOR EXPEDITED REQUEST

SIGNATURE
MENTAL HEALTH AREA STAFF

PHONE