

SINGLE BED CERTIFICATION

Fax requests to: WSH Director of Social Work: 253-756-2323 (M-F 7a.m.- 4p.m.)
After 4:00 PM & Holidays: WSH Director of Nursing: FAX#: 253-756-2873

RSN Requesting Certification: _____

Facility Utilizing the Certification: _____

RSN Designated Person Making Request: _____
Name/Title

FAX _____ Phone _____

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Patient Name _____

DOB _____ SSN _____

Legal Status _____

Criteria for Requesting Certification: (choose one)

- (a) The consumer requires services that are not available at a facility certified under this chapter (WAC 388-865-0500) or a state psychiatric hospital.
- (b) The consumer is expected to be ready for discharge from inpatient services within the next thirty days and being at a community facility would facilitate continuity of care, consistent with the consumer's individual treatment needs.

If patient is an adolescent, is this request for an adult unit?

Estimated Length of Certification: _____ Days From _____ To _____

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FOR USE BY WSH STAFF

Certification Approved By _____

Date: _____

Phone: 253-756-2524 or 756-2966