____
(ADD DATE)

To: Western Area Respite Coordinator
Western Community Health Resources
300 Shelton St.
Chadron, NE 69337

Fax: 308-432-8974

Email: respite@wchr.net

_________________________________ is my patient. This family could benefit from
(WRITE IN NAME OF INDIVIDUAL WITH SPECIAL NEEDS)

respite. This person has the following diagnosis ___________________________________

____

This diagnosis results in the following behaviors or medical needs: ______________________

____.

PROVIDER INFORMATION

___________________________ ___________________________
(PRINTED NAME OF PROVIDER) (PROVIDER'S SIGNATURE)

___________________________ ___________________________
(DATE) (NAME OF AGENCY OR PRACTICE)

_________________________________ ___________________________
(NAME OF AGENCY OR PRACTICE) (PHYSICAL ADDRESS)

_________________________________ ___________________________
(MAILING ADDRESS) (CITY, STATE, ZIP CODE)

_______ - ______ - __________ _______ - ______ - __________
(PHONE) (FAX)

____
(EMAIL ADDRESS)