

Adult Day Health Center

QUARTERLY REVIEW ATTACHED

To: _____ Date: _____

Phone: _____ FAX: _____

From: _____

REQUESTED ACTION

To ensure continued services for your patient/client

Please initial & date after reviewing and fax to (253)_____.

Required by Washington Administrative Code (WAC) for Adult Day Health Services.

In addition, any comments or further orders you have would be appreciated. Thank you for your time and consideration.