WESLEY Medical Center
550 N. Hillside • Wichita, KS 67214-4976
(316) 962-2000 • www.wesleymc.com

FROM:

PHYSICIAN OFFICE: _____

FAXED BY: _____

TO:

FAX SERVER
FAX: (316) 962-7827
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NUMBER OF PAGES: _____
(Following this sheet)

INSTRUCTIONS:

1. Please send this cover sheet with all faxed information.
2. Please complete all applicable categories.
3. For efficient/accurate processing – One fax cover sheet per patient.
4. Identify each sheet of information with the patient's name - to reduce medical-legal risk.

PATIENT'S FULL LEGAL NAME: _____
(Please Print Legibly)

DATE OF SERVICE:_____/_____/_____ **SSN#:** _____-_____-_____

DATE OF BIRTH:_____/_____/_____ **EDC for OB pts:**_____/_____/_____

Level of Care: ☐ Inpatient ☐ Outpatient Procedure ☐ Outpatient with Observation services
For _____
(not applicable for Surgeries)

Patient: ☐ Adult ☐ Pediatric (under 18 years old)

Type of Service: ☐ Surgery
☐ Admit day of
☐ Admit prior to day of
☐ Medical
☐ Obstetrics
☐ Testing and/or Procedures
Ex : Lab, X-ray, Ekg, POA
☐ Recurring
Ex : Infusion, Wound Care, PT, OT
☐ Cardiac Procedures-outpatient
Ex : Heart Caths, EP
☐ Other_____

5. Obtain confirmation from your fax machine.
6. Contact Fax Server Help Line at 962-7234 for assistance.
7. Obtain additional fax server coversheets from the Help Line.

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