



## Patient Location Request

**Instructions:** To request a patient location, you must fill out this form and fax it to the Data Department at (323) 962-0127. **Requests will be processed by fax within 5 business days.**

**Facility/Transplant Section:**  
(Please Print Clearly)

Patient Name: \_\_\_\_\_  
Patient D.O.B.: \_\_\_\_\_  
Patient SSN: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Patient D.O.B.: \_\_\_\_\_  
Patient SSN: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Patient D.O.B.: \_\_\_\_\_  
Patient SSN: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Patient D.O.B.: \_\_\_\_\_  
Patient SSN: \_\_\_\_\_

**Network 18 Section:**  
(For Network Use Only)

Location: \_\_\_\_\_  
Event: \_\_\_\_\_  
Date: \_\_\_\_\_  
First Date of Dialysis: \_\_\_\_\_

Location: \_\_\_\_\_  
Event: \_\_\_\_\_  
Date: \_\_\_\_\_  
First Date of Dialysis: \_\_\_\_\_

Location: \_\_\_\_\_  
Event: \_\_\_\_\_  
Date: \_\_\_\_\_  
First Date of Dialysis: \_\_\_\_\_

Location: \_\_\_\_\_  
Event: \_\_\_\_\_  
Date: \_\_\_\_\_  
First Date of Dialysis: \_\_\_\_\_



**REQUESTED BY:**

Date: \_\_\_\_\_ Provider #: \_\_\_\_\_  
Name: \_\_\_\_\_  
Facility Name: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_