



Harris County Hospital District

Referral for Inquiry

Patient: _____

Account #: _____

Admission: _____

Discharge: _____

D.O.A. _____

Pavilion or PTL (Primary Treatment Location):

Specific Action Requested:

Attached are "all detailed" copies of the patient's record.

Signature: _____ Date: _____

Audit Findings:

Signature: _____ Date: _____