North Central EMS
Communications Center
Ph: (419) 499-2515
Fax: (419) 499-2216

File: transportationrequestform.doc
Date: 9/10/2015

SCHEDULED TRANSPORT FAX REQUEST

Requesting Facility Information

Requesting Facility: _____

Department / Room #: _____

Requesting Doctor: _____

Phone: _____ Fax: _____

Date of Transport: _____ Requested Time_____

Contact Person: _____

MODE OF TRANSPORTATION

- □ Ambulance
- □ Bariatric Ambulance (Over 350#)
- □ Confined Wheelchair Regular Size
- □ Confined Wheelchair Wide Size
- □ Hospital Shuttle (Wheelchair assist to/from van)
- □ Hospital Shuttle (Can ambulate & with assistance)
- □ Hospital Shuttle (Walks without assistance)
- □ Mobile ICU (includes Nurse and Medic with the patient)

PATIENT'S INFORMATION

Pt's Name: _____Weight#:_____

Pt's SSN: _____DOB:_____

Provide Patient Hospital I.D. Sticker Here

DESTINATION INFORMATION

Receiving Facility: _____

Department / Destination: _____

Doctor's Name: _____

Phone: _____ Fax: _____

Date of Transport: _____ Appointment Time_____

Bed Confined is defined as a patient who is unable to get up from bed AND unable to ambulate AND unable to sit in chair.	**Bed Confined?** □ YES □ NO

Diagnosis:

What is the patient's condition that requires an ambulance transport?

Reason for transfer from facility?
- □ Medically Indicated
- □ Trauma
- □ Other: _____
- □ Patient Requested
- □ Doctor's Appointment

Can service, treatment, or procedure be provided at the sending facility?	**Available at Facility?** □ YES □ NO

Check all that apply:
- □ EKG/Cardiac Monitor
- □ Ventilator
- □ Oxygen @ ____LPM
- □ Suction / Trach. Care
- □ Blood Transfusion
- □ Chest Tube
- □ IV Fluids: _____
- □ Physical Restraints

INSURANCE COVERAGE

- □ Medicare #:_____
- □ Medicaid (Traditional) #:_____
- □ Aetna Better Health Medicaid:
  Call (866) 799-4395
  Auth #:_____
- □ Molina Medicaid: Call (866) 642-9279
  Auth #:_____
- □ UnitedHealth Medicaid: Call (800) 269-4190
  Auth #:_____
- □ Caresource Medicaid (Wheelchair only):
  Call (866) 531-0615
  Auth #:_____
- □ Buckeye Medicaid (Wheelchair only):
  Call (866) 531-0615
  Auth #:_____
- □ Private Insurance: _____
- □ Self Pay
- □ Patient *skilled* at time of transport?
- □ Bill Facility

FAX this form, current demographics sheet, and a PCS or cert (if needed) to the NCEMS Communications Center. The communications center will process your request and contact you regarding a scheduled time of pickup. If information is incomplete it will cause delay in scheduling your request.