1851 Aucutt Rd, Montgomery, IL 60538
Dispatch/Transport Fax: 888.972.4996
Phone: 630.898.2117

AMBULANCE TRANSPORT REQUEST FORM v1.1

Facility: _____ Return fax #: _____

Patient name: _____ Social security #: _____

Date of birth: _____ Room number: _____ PT weight: _____ ☐ lbs | ☐ kgs

☐ Bariatric Ambulance (weight above 350 lbs/158 kg)	☐ Recurring Transport (requires 'Supplemental Form')

Why does PT require ambulance for transportation? *(Check any that apply)*

☐-Two Person/Max Assist/Hoyer Lift/Mechanical Transfer | ☐-Dementia, Alzheimer's Disease | ☐-Uncapped trach site
☐-Unable to maintain safe sitting position/special positioning required due to:_____
☐-PT on isolation precautions for: _____ | ☐-PT on more than 3L of O_2, amount of O_2: _____

Any additional reasons patient requires ambulance for transport as opposed to other means:

_____

_____

Destination address: _____

_____

Suite #/Department/Location: _____| ☐-Outpatient Registration |☐-Oncology/Cancer Center

Name of Doctor/Provider appt is with: _____ **Phone Number:** _____

Nature/Type of appointment: (*Check any that apply to this transport*)

☐-PCP/Internal Medicine | ☐-Orthopedic/Ortho Surgery F/U | ☐-Ophthalmology/Eye | ☐-Oncology/Hematology
☐-Urology | ☐-Gynecology | ☐-Neuro | ☐-Cardio | ☐-Dental/Orthodontics | ☐-Nephrology | ☐-Gastrology

Additional treatments/appointment types:

☐-MRI | ☐-CT Scan | ☐-X-Ray | ☐-Blood & Lab Diagnostics | ☐-Swallow Study/VFSS/Endoscopy/EGD | ☐-Biopsy
☐-X-Ray | ☐-Stress Test | ☐-Ultrasound/Doppler | ☐-Pre-Surgical Diagnostic/Clearance Appt | ☐-Mammogram
☐-Radiation | ☐-Chemotherapy | ☐-Wound Debridement/Treatment | ☐-PICC Line, G Tube/J Tube Placement
☐-Procedure: _____

☐-**Other/Appointment type not listed:** _____

Date of transport: _____ Appointment time: _____ AM / PM ☐-Family/Escort to Accompany

SAME DAY OR NEXT DAY APPOINTMENTS MUST BE CALLED IN TO 630.898.2117. All other requests must be faxed.

REQUIRED OF PERSON COMPLETING FORM PRIOR TO FAXING REQUEST	**Ridge Staff Only**
Name (first & last/initial, must be legible): _____ Signature: _____ **Credentials:** ☐-Reg. Nurse | ☐-Discharge Planner | ☐-Other: _____	**Pick Up Time:** Entered by:

Transportation not confirmed until you receive a return fax with pick up time completed by Ridge staff. If you do not receive a response to the provided return fax by the next day, please call dispatch to inquire before re-faxing request.

** PDF and Typable Versions of forms available via email or by visiting RidgeEMS.com/Transport **