



1851 Aucutt Rd, Montgomery, IL 60538

Dispatch/Transport Fax: **888.972.4996**

Phone: 630.898.2117

MEDVAN TRANSPORT REQUEST FORM v1.1

Facility: _____ Return fax: _____

Patient name: _____ Social security #: _____

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

Wheelchair size limit for Medvans is 'Size 26' absent customization/add-ons.
Patients transported in wheelchairs must have functioning leg rests.
Patients must be able to stand/pivot transfer with a one person assist or less to be Medvan appropriate.
Medvan transports to destinations within city limits of Chicago require an escort.
Ridge Transport is unable to transport broda/geri chairs, high back chairs, or electric/motorized wheelchairs.

Is patient on oxygen? -No | -Yes, amount: _____ (Medvan limit is 3L of oxygen)

Is patient on isolation? -No | -Yes, for: _____ (PTs on ISO must go via ambulance)

Is patient able to stand/pivot transfer with a 1 person assist? -Yes | -No (PTs must be able to stand/pivot transfer)

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****

Name (first & last/initial, must be legible): _____

Signature: _____

Credentials: -Reg. Nurse | -Discharge Planner | -Other: _____

****Ridge Staff Only****

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 **