



Ambulance & Wheelchair Pre-Scheduling Request Form

PRE-SCHEDULED STRETCHER TRANSPORTS ONLY

For unscheduled trips (discharges, short notices or urgent trips) please call the office

FAX TO 843-264-2604



Place patient sticker here

Level of Service Needed (circle one) Ambulance Wheelchair

Appt. Date	
Pick Up Time	
Appt. Time	

Patient's Name: _____
 Address _____ City _____ State _____ Zip _____
 SSN _____ DOB _____ Height _____ Weight _____
 Medicare # _____ Medicaid# _____
 Private Insurance _____ Policy# _____ Group# _____

Transported From

Facility Name _____ Room#/Dept/Dr. _____
 Address _____ City _____ State _____ Zip _____
 Phone _____ Fax _____ Other _____

Transported To

Facility Name _____ Room#/Dept/Dr. _____
 Address _____ City _____ State _____ Zip _____
 Phone _____ Fax _____ Other _____

Please complete the following:

1. Special Instructions

(Example #1) Pt receives dialysis treatments every Monday, Wednesday and Friday from 11:00am-2:00pm; place on permanent schedule. (Example #2) Pt receives wound care every Tuesday at 10:00am, place on permanent schedule. (Example #3) Pt has wound vac, NG tubes, requires oxygen at 2 LPM via nasal cannula, etc

- 2. Ambulance Certification or (PCS) Form Attached? (must be received prior to transport) Yes/No
 - 3. Is this patient enrolled in Hospice? Yes/No
 - 4. Patient Demographic/Face Sheet Attached? (must be received prior to transport) Yes/No
 - 5. Does this patient require a stretcher/ambulance? Yes/No
 - 6. Does the patient require oxygen? Yes/No
 - 7. Does the patient require suctioning en-route? Yes/No
 - 8. Does the patient require active on-going medical care during transport? Yes/No
 - 9. **Nursing Facilities Only.** Is this patient within their 100 day stay? Yes/No Admit Date _____
 - 10. Reason For Transport (RFT): Dialysis, CT Scans, MRI, Bone Scan, Doppler Studies, Cardiac Catherterization, Angiography, Lymphatic and Venous Procedures, Radiation Therapy, Peg Tube Procedures, Wound Care, Foley/Suprapubic Cath Procedures, Chest X-ray, Barium Swallow, Outpatient Surgery
- Other _____

Facility Name _____ Requested By _____ Title _____ Date _____