

A-TEC Ambulance, Inc. / Integrity Medivan Service
Fax: 847-458-6396

Requesting Facility:

Facility Name: _____ Room Number : _____

Facility Representative and Title: _____

Fax #: _____ Phone #: _____

Please selected the type of transport the patient's condition requires AT TIME OF TRANSPORT:

- Service Car** - Transportation by passenger vehicle of a patient whose medical condition does not require a specialized mode
- Medivan** - Transportation of a patient whose medical condition requires the use of hydraulic or electric lift or ramp, locking devices
- Non-emergency Ambulance** - Transportation of a patient whose medical condition requires transfer by stretcher and medical monitoring

Patient Information:

Last Name: _____ First Name: _____ M: _____

DOB : _____ SSN: _____

Medicaid Recipient #: _____ Medicare #: _____

Prior Approval Number: _____

Trip Information:

Date: _____ Appointment Time: _____

Physicians Name: _____ Physician's Number: _____

Reason for transport: _____

Originating Facility Information:

Facility Name: _____ Contact Phone: _____

Facility Address: _____

City: _____ County: _____ State: _____ Zip: _____

Destination Information:

Facility Name: _____

Facility Address: _____ Suite #: _____

City: _____ County: _____ State: _____ Zip: _____

Patient Needs:

- Contractures Non-healed fractures Patient is confused Patient is comatose Moderate/severe pain on movement
- Danger to self/other IV meds/fluids required Patient is combative Need or possible need for restraints
- DVT requires elevation of a lower extremity Medical attendant required Requires oxygen – unable to self administer
- Special handling/isolation/infection control precautions required Unable to tolerate seated position for time needed to transport
- Hemodynamic monitoring required enroute Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds
- Cardiac monitoring required enroute Morbid obesity requires additional personnel/equipment to safely handle patient
- Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport Escort Required

For Office use only:

Received Request: _____ Pick Up Time and Date: _____

Dispatcher: _____ Acknowledgement Date: _____

Please fill out one per patient