# EAST AMBULANCE

(937)780-6520 (800) 215-7366 FAX (937) 780-6758

## SCHEDULED MEDICAL TRANSPORTATION FAX

PICK UP DATE ________/________/________ APPT. TIME: ________________

PATIENT NAME ______________________________________________ RM # ___________

PICK UP LOCATION:__________________________________________________________

DESTINATION: ______________________________________________________________

PHYSICIAN/SPECIALIST BEING SEEN: ___________________________________

PROCEDURE/TREATMENT BEING PERFORMED____________________________

PATIENT WEIGHT: ________lbs DOES PATIENT NEED OXYGEN _________

INFECTIOUS PRECAUTIONS/SPECIAL CARE_________________________________________

W/C ________ DOES PATIENT USE WIDE WHEELCHAIR ____________

STRETCHER _________ MEDICAL REASON FOR STRETCHER___________________________

PRIMARY CARE PHYSICIAN: ___________________________________________________

SCHEDULER/CONTACT NAME __________________________ **FAX THIS FORM TO (937)780-6758**

YOU WILL RECEIVE A FAX COPY WITH A CONFIRMATION NUMBER AS VERIFICATION THAT THIS FAX WAS RECEIVED. IF YOU DO NOT RECEIVE A CONFIRMATION FAX BACK, PLEASE CALL US.

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CONFIRMATION (OFFICE USE ONLY)

CONFIRMATION NUMBER __________________ DATE OF CONFIRMATION ________/________/________

**PICK UP TIME: ______________________** CONFIRMED BY: _________________________________

Revised 08/06/2010