**MUSKOKA**

PATIENT

*STRETCHER TRANSPORT BOOKINGS*

*Call 1-705-330-9111*

**TRANSPORTATION**

NON-EMERGENCY TRANSPORT REQUEST FORM

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Booking Facility | Contact Name: | | | Contact Phone No: | | **PICK UP TIME MUST BE AT LEAST ONE HOUR PRIOR TO APPOINTMENT** | |
| Pick Up Date: | Pick Up Time Required | | | Appointment Time: | | Pick Up Phone No: | |
| Pickup Location: (include full address) | | | Ward/Dept/Residence: | | | | |
| Destination: (Include full address) | | | Ward/Dept/Residence: | | | | |
| Surname of Patient | | Given Name of Patient | | | Age of Patient | | Weight of Patient: |
| Isolation Concerns  Does the patient have/had a new or worsening cough? Yes O No O  Has the patient feel/felt feverish, had shakes or chills in the last 24 hours? Yes O No O  Has the Patient have/had a headache, sore throat, muscle pain, abdominal pain, vomiting or diarrhea? Yes O No O  Has the sending or receiving Facility a reported outbreak? Yes O Kind: No O | | | | | | | |
| Isolation Precaution Required: Yes O No O | | | If answered Yes Details of Isolation Status: | | | | |
| Patient For:  O Admit/Discharge  O Day Surgery  O Other (Specify) | | | | Responsible Party:  O Patient  O Hospital  O Other | | | |
| Special Requirements: (if Any) | | | | Escort  MEDICAL O FAMILY O  Name and Contact information for Escort | | | |
| Any Equipment/Mobility Aids: (Specify) | | Return Trip:  Yes O Pickup Time No O | | | Valid DNR No: | | |