BEST CARE AMBULANCE SERVICE, INC.

Schedule Multi-trip Transport Form

General Information

Sending Facility: ____________ Dep./Rm# ________ Today's Date: / /

Staff Member Requesting Transfer: ____________ Call Back Phone Number:( ) -

Facility Fax Number: ( ) - ________ Email address (optional): ____________

Patient's Information

Name: ____________ **Age:** ______ **Sex:** ☐ **Male** ☐ **Female** **Weight:** ______ **Lbs**

Level of Consciousness: ☐ **Alert** ☐ **Verbal** ☐ **Pain** ☐ **Unresponsive**

Chief Complaint: ____________

Onset: ____________

Medical History: ____________

Diagnosis/Rule Out: ____________

Does the Patient has an Out-of-Hospital D.N.R.? ☐ Yes ☐ No

Multi-trip Times

Starding Date: / / Ending Date: / /

☐ **Sunday** ☐ **Monday** ☐ **Tuesday** ☐ **Wednesday** ☐ **Thrusday** ☐ **Friday** ☐ **Saturday**

Pick Up Date & Time: / / : **AM/PM** **Return Date & Time:** / / : **AM/PM**

Equipment & Special Instructions (Check and fill up all that apply)

Oxygen ☐ Oxygen Rate: ______ Route Administrated: ______

Ventilator ☐ Tidal Volume: ______ Rate: ______ PEEP: ______

IV Pump ☐ Infusions & Rate: ______ **Meds. Required enroute:** ______

Cardiac Monitor ☐ Other: ______ **Are there any stairs at either location?** ______

Notes:

Receiving Facility

Name	Street Address	Dep./ Suite / Apt#	City	Zip Code

Report given to: ____________ **Admittance Physician:** ____________

Payment Details

☐ **Bill Facility** ☐ **Medicare** For Medicare CMN form must be faxed to Best Care EMS Dispatch at the time of Transport.

☐ **Medicaid** *Terms & Conditions as per Medicare Rules & Regulations.

☐ **Private Insurance** Insurance Company Name: ____________ Authorization #: ______

☐ **Private Pay** Phone #:( ) - Policy #: ______ Group #: ______

Toll: 1 (800) 686-3588 - Tel: (713) 661-3830 - Fax: (713) 661-1457 / 3830

Visit us www.BestCareEMS.com

"People Helping People"