Illinois Patient Transport
a division of Advanced Medical Transport of Central Illinois
Behavioral Health Services

Behavior Health Service Transport Request Form

DOS ____________________

Phone: 877-745-8367
309-999-4040

Fax: 309-494-6227

Does the Patient have Managed Medicaid (MCO)? YES ☐ No ☐

Patient Name: ______________________ Age: ________ DOB: ________ Gender: M F

Address: ______________________ City: ________ State: ________ Zip: ________

Phone: ______________________ Emergency Contact: ______________________

SSN: ______________________ Emergency Contact Phone: ( ) ______________

Insurance1: ______________________ Policy #: ______________________

Insurance2: ______________________ Policy #: ______________________

Transferring Facility

County of Originating Facility: ______________________

Transferring Facility: ______________________ Room: ________ Phone: ( ) ______________

Address: ______________________ City: ________ State: ________ Zip: ________

Requesting/Contact Person: ______________________ Contact Phone: ( ) ______________

Destination Facility

County of Destination Facility: ______________________

Destination Facility: ______________________ Room: ________ Phone: ( ) ______________

Address: ______________________ City: ________ State: ________ Zip: ________

Contact Person: ______________________ Contact Phone: ( ) ______________

Has the Destination Facility agreed to admit the patient? YES NO

Certificate & Petition for Involuntary/Judicial (Court Order) Admission

All forms have been completed, signed and faxed with this transfer request. YES NO

Note- transporting units will be dispatched only after receipt of: completed Transport Request Form, Hospital Face Sheet, Certificate and Petition, (or Court Order in lieu of Certificate and Petition).

Pre-transport Risk Assessment

Question		
1. Do physical limitations prohibit transport by car; ambulatory, weight, or other?	YES	NO
2. Is the patient a juvenile?	YES	NO
3. Does the patient require restraints for transfer?	YES	NO
4. Are there identified complicating medical conditions with potential for difficulty enroute?	YES	NO
5. Was there assaultive behavior in connection with this admission?	YES	NO
6. Was there use of PRN medications for agitation with this admission?	YES	NO
7. Does the patient exhibit imminent suicidal ideations?	YES	NO
8. Does the patient have a recent history of attempted elopement (fleeing the hospital)?	YES	NO
9. Do these answers accurately reflect the Uniform Screening and Referral Form?	YES	NO
10. Is the patient sufficiently stabilized for transport?	YES	NO

Fax Completed Form to: 309-494-6227 **and** provide a copy to the IPT Driver

©, 2011, Advanced Medical Transport of Central Illinois