

DOS \_\_\_\_\_

**Fax: 309 494 6227**

**Patient Information**

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**

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**