YUKON-KUSKOKWIM HEALTH CORPORATION

Patient Transport Order — Memorandum of Transfer

Travel Date: _____
Dispatched ☐ ANC ☐ BET
Chart # _____

Patient Information

Patient at: ☐ ER ☐ Inpatient ☐ OB ☐ Peds ☐ Fam. Med. ☐ Other _____
Patient Name: _____ ☐ M ☐ F DOB: _____ SS #: _____
Patient Mailing Address: _____ City: _____ State: _____ Zip: _____
Patient Phone: _____ Race: _____ Religion: _____
Next of Kin: _____ Relationship: _____ Phone: _____

To be completed by Physician

Transfer Information and Medical Provider Orders

Diagnosis: _____ Advance Directive ☐ Yes ☐ No

Medical Necessity (check one):
☐ **Higher level of care required, not available in Village**
☐ **Patient services required are not available at this facility**

IV: _____ @ _____ ml per hour. O_2 @ _____ L/Min via ☐ Mask ☐ Cannula
Orders/:Meds: _____

☐ **Critical Care** ☐ **Urgent**: Within ____ 6 hrs. ____ 12 hrs.
☐ **Emergency Charter** (from _____ to: _____)
☐ **Routine/Referral:** _____
appt: _____ / _____
appt: _____ / _____
Transferring Facility: _____
Address: _____
Contact Person: _____

Attachments: ☐ Face sheet ☐ H&P ☐ Lab Reports
☐ M.D. Progress Note ☐ Medication Record
☐ X-Ray Reports ☐ Other

MANDATORY ☐ **Consent and Certification Form MUST accompany patient**

Mode: ☐ Stretcher ☐ Wheelchair ☐ Ambulatory
☐ Isolette ☐ Other _____
Escort: ☐ ALS ☐ BLS ☐ CHA/CHAP
☐ Family ☐ None ☐ Other _____
Cabin Pressure: ☐ Sea Level ☐ Regular (5,000 - 8,000)

Accepting Physician: _____
Accepting Facility: _____
Address: _____
Contact Person: _____
Date Facility Contacted _____ Time: _____
Date Facility Accepted _____ Time: _____
Non-Admit: ☐ Quyana House ☐ Bethel Hostel
☐ Other _____
Admit: ☐ ER ☐ ICU ☐ OB ☐ Peds ☐ Other _____

I certify that this transport is a medical necessity and that services required are not currently available at this facility.

_____ / _____
Physician Name (print *Physician Signature* *date* *time*

Physician signature = administrative approval

To Be Completed by Travel Management Center or Communications Center

Travel Information

Escort Names: _____
Medicaid #: _____ Medicaid PA # _____ Insurance Provider: _____ Insurance #: _____
TA# _____ Cost: _____ Airline: _____ Aircraft Type: _____ Flight Date and Time: _____
Lodging: ☐ Hotel ☐ Other _____

Ground Transport:
Origin: _____
☐ Ambulance ☐ Wheelchair Van ☐ BFD Ambulance ☐ Cab ☐ Aeromed Van ☐ Other _____
Destination: _____
☐ Ambulance ☐ Wheelchair Van ☐ Aeromed Van ☐ Cab ☐ Other _____

PATIENT INFORMATION

Acct. #: _____
HR#: _____ DOB: ____ / ___ / ___
Name: _____
Last *First* *MI*
Residence: _____ Facility: _____
Date of Service: _____