# 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: ____________