# 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: ______________________