Hospital Discharge Transportation Request

Member Name:	DOB:	CIN:
Member Phone Number:	Interpreter needed (If yes, inc. language):	
Requestor Name, Title:	Requestor Ph. #:	
Discharging Facility Name:	Facility Fax #:	

Medical Information		
Member's Height (In.):	Member's Weight (lbs)	
O2 (liters):	Does O2 Need to be Provided? Select One	
Mobility Equipment: Select One	Does Wheelchair Need to be Provided? Select One	
Vent or Trach: Select One	Other Medical Equipment (list):	
Behavior or Precautions:	Bathroom On Own: Select One	

Pick-up Information			
Level of Service: Select One			
Expected Discharge Date:	Expected Discharge Time:		
Pick-up Address (inc. floor and/or room #):		Best Contact #:	
# Adult Attendant(s):	# Child Attendant(s):	Service Animal (species and weight):	

Drop-off Information	
Drop-off Address:	Best Contact # for Drop-off:
# Of Stairs or Ramp at Drop-Off Location:	

Additional Notes	
Completed By:	**Date:**

Complete for Facility-to-Facility Transfers	
Sending Facility:	Contact Name & Phone Number:
Receiving Facility:	Contact Name & Phone Number:

Fax: **(530) 351-9055** | Email: transportationhelpdesk@partnershiphp.org

Email subject lines must include the discharge date

5150 requests must include "Urgent 5150" in the email subject line

If NEMT is requested, a completed and signed PCS form is required