

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**