Hospital Discharge Transportation Form

Date of Requested Ride: _____ Rider's Name:_____

Email: _____ Phone # _____

Full Address: _____

Hospital Contact: _____ Phone # _____

Email: _____

Hospital Address: _____

Pick-up Location: _____
(Ex: Which Door)

Discharge Time: _____ Drop Off Location:_____
(Ex: Facility, Relative, Home)

Rider Considerations:

⇒ Will there be somebody at the drop off location	◉ Yes	○ No
⇒ Escort *(No Additional Charge)*	◉ Yes	○ No
⇒ Can they get into a minivan *(Stand, Twist, Lift Legs)*	◉ Yes	○ No
⇒ Do we need to bing a wheelchair van	○ Yes	◉ No
* Will they have their own wheelchair upon discharge	○ Yes	◉ No
* If so, what size is the wheelchair	○ Standard	◉ Bariatric

⇒ Will they be bringing any other hospital equipment with them _____
(Ex: Oxygen, Walker)

Payment Method _____

Special Instructions _____