KCTS Hospital Discharge Form

308-235-0262 / email back to reservations@ridekcts.com

Date of this request: ________________ Rider's Name: ______________________________ Rider's Phone#: ____________________

Rider's Email: ___________________________ Rider's Address: ____

KCTS doesn't provide assistance with bathroom use, medication, or other personal care. Personal Care Assistant rides free.

Is there a PCA? Name of PCA: ___________________________ PCA's Ph #: _______________________

Point of Contact after they leave facility (family meber, receiving facility, etc): ____

Hospital Contact –Who do we contact to verify details of ride?

Name: ___________________________ Phone#: ______________________ Email: _______________________________________

Discharge Date: ____________________ Discharge Time: ________________ Discharge Hospital: ____________________________

Specific location of pick-up (Door#, etc): ____

Specific location of drop-off (home, rehab, etc): ____

Important information to ensure ride is handled properly and the rider has a safe comfortatble ride.

We want to be prepared and professionally handle this ride. Please consider the rider and the important details needed to make a ride successful. This information hlps us determine the type of vehicle, route and supplies needed to complete the ride.

- ⇒ Will someone be riding along to assist the rider? *(No additional charge)* Yes No
- ⇒ Will there be somebody at the drop off location? Yes No
- ⇒ Is there any concerns about the travel distance? Yes No
  - ♦ How will medication affect them during travel? ______________________
  - ♦ Will they be able to use a bathroom or need depends undergarments?
  - ♦ Do they have the appropriate amount of oxygen?
  - ♦ Do they have clothing and footwear?
  - ♦ Will they need a vomit bag?
- ⇒ Can they get into a minivan? (stand, twist, lift legs) Yes No
- ⇒ Do we need to bring a wheelchair? Yes No
  - ♦ Standard or bariatric size wheelchair? ___________________
- ⇒ Is there any other mobility concerns we should be aware of? (Walker, prosthetic, etc) Yes No
- ⇒ Are there any language or speech concerns we should be aware of? Yes No
- ⇒ Will they be brining any hospital equipment with them? Yes No

Payment Method: Please circle and additional details as needed.

Self-pay Medicare Medicaid Hospital Voucher Other

Special Instructions: ____

I understand by signing this form I agree the information given is accurate. If the ride fails due to incorrect information about the riders ability, condition, mobility/accessibility or escort requirements. The dead head fee of $125 is due before the ride can be rescheduled.

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Medical Provider Signature