Index: 6080.000
Addendum: #1

Today's Date: _____

Completed By: _____

Patient's Name: _____

Age: _____ Birth Date: _____ Weight: _____

Social Security #: _____ Room #: _____

Address: _____

_____ Phone #: _____

Name of Relative: _____

Address: _____

Relation: _____ Phone #: _____

Responsible for Bill: _____

Diagnoses: _____

_____

_____

Pt's MD: _____ Phone #: _____

Transport To: _____

Address: _____

Day/Date: _____

Pick-Up Time: _____

Call: **LOCAL SQUAD** _____

Which One _____

PRIVATE SQUAD _____

Reason for Transport: _____

Information to go with Patient: _____

_____

WHEELCHAIR: _____ **STRETCHER:** _____

Nurse Needed?* _____ Yes

Special Equipment Squad Should Have: _____

_____

Date/Test: _____ Time: _____

Appointment Made By: _____

Date Made: _____ Time: _____

Should Squad Wait? _____ Yes _____ No

Other Pertinent Info: _____

_____

TO BE COM

Name of Squad Called: _____

_____

By Whom: _____ Date/Time: _____

By Whom: _____ Date/Time: _____

Confirmed by Squad Member, who? _____

Day/Date: _____ Time: _____

Date Confirmed For: _____

Pick-Up Time: _____ Arrival: _____

*Nurse: _____ Time Out _____ In _____

CANCELLED When? _____

Reason: _____

By Whom: _____

Rescheduled For: _____

Squad Called: _____

By: _____ Date/Time: _____

Date Confirmed For: _____

*Nurse: _____

INSURANCE INFORMATION

Insurance #: _____

Insurance Co.: _____

Address: _____

Employer: _____

Medicare #: _____

Medicaid #: _____

*Miscellaneous Charge Slip to be completed and sent to Nursing Office.

Number Info to be Faxed To: _____

HCH Fax # _____

HCH Phone # _____

hackettstown community hospital
651 WILLOW GROVE STREET • HACKETTSTOWN • NEW JERSEY 07840-1798 • PHONE (908) 852-5100
FAX (908) 850-8604

4253 (12/97)

RESCUE SQUAD TRANSPORTATION FORM