LEON COUNTY
EMERGENCY MEDICAL SERVICES

EMS TRANSPORTATION REQUEST

Please Complete Form in its entirety and fax to (850) 921-4100 with all other required forms.

Desired Date:	**Time:**	**Requestor:**
Patient Name:		**DOB:**

To be Transported From: (Facility, Address, Room number, and Phone number)

To be Transported To: (Facility, Address, Room number, and Phone number)

Transport Details: (Please include diagnosis and special care required for transport, IV infusions, CPAP, isolation precautions, etc)

Contact for Transport:

Name: Phone: Fax:

Payment Status: (circle one) **Health Insurance** **Workers Comp** **Auto Insurance** **Self-Pay**
Medicare **Medicaid** **Facility to Cover Cost** **Agency to Cover Cost**

Responsible Party:

Address: City, State, Zip: Phone#

Insurance Co: Policy# Group# Approval#

Address: City, State, Zip: Phone#

Cost: (Base Transport Cost + mileage) (Call (850) 921-0900 for Quote)	$

☐ Price Quote Requested
☐ Physician Certification Statement Faxed to 921-4100
☐ Current Demographic/Face sheet Faxed to 921-4100
☐ Insurance Information Faxed to 921-4100
☐ Bed available at receiving facility - Rm # _____

Requesting Staff Signature X _____
Print Name & Title:

EMS DISPATCH USE ONLY

Controller Receiving Request: _____

Time of initial call (requesting quote): _____
Time Completed Paperwork Received: _____
Time facility noitfied of ETA: _____
Time Ambulance arrived for pick-up: _____
Time Ambulance departed for trip: _____

Delays:

Transport Completed by LCEMS ☐ *Yes* ☐ *No*

Leon County
Emergency Medical Services
1800-2 N Blair Stone Rd
Tallahassee, FL 32308

Preserving Life, Improving Health, Promoting Safety