STANDING ORDER FORM

FAX # 877.813.5599
PHONE # 866.469.2824

		☐ **New** ☐ **Update Existing**
Member Name:	**Medicaid #:**	**DOB:** _____/_____/_____
Facility Name:	**Phone #:**	**Fax #:**

APPOINTMENT INFORMATION

Days		
☐ Mon ☐ Tue ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun	**Appt. Time:** ____________ ☐ **AM** ☐ **PM** **Return Time:** ____________ ☐ **AM** ☐ **PM**	☐Ambulatory ☐ Cane ☐ Walker/Rollator ☐ Escort (*If Member resides ½ mile or less from a fixed route stop, he/she must use mass transit* ***unless*** *a mass transit restriction form is on file*)
	Start Date: _______/_______/_______ **End Date:** _______/_______/_______	☐ Wheelchair ☐ Manual ☐ Electric Is the member able to transfer to an ambulatory vehicle: ☐ Yes ☐ No
	Weight: __________ **Height:** ___________ **Stairs:** ___________	☐ Stretcher ☐ Oxygen ____ Liters ☐ Isolation (*Medical Necessity Form required for* ***all*** *stretcher transport requests*)
	Treatment Type:	**Special Needs:**

PICK-UP INFORMATION

Facility/Residence:	**Address:**
City/State/Zip:	**Room/Apartment #:**
Phone #:	**Alt #:**

DROP-OFF INFORMATION

Facility Name:	**Address:**	
City/State/Zip:	**Building Name:**	**Suite #:**
Phone #:	**Physician / Department:**	

NAME: ________________________ **SIGNATURE:** ______________________ **TITLE:** _______________________

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