NIH CLINICAL CENTER

PATIENT SUPPORT SERVICES DEPARTMENT

Admissions Office Phone: 301-496-3315 (24/7) FAX #: 301-402-0664

AMBULANCE REQUEST FORM

TODAY'S DATE: ________________TIME:_________ DEPARTMENT OR I/C: _______________

REQUESTER NAME: ____

REQUESTER TELEPHONE #: _____________________ PAGER #:_________________________

PLEASE SELECT ONE OF THE OPTIONS BELOW:

OPTION 1: ☐ **ADMISSIONS TO MAKE AMBULANCE ARRANGEMENTS**

Complete **SECTIONS A** *AND* **B**

☐ NON-URGENT (ambulance needed >2 hours) ☐ URGENT/EMERGENT

OPTION 2: ☐ **NOTIFICATION OF AMBULANCE TRANSPORT (ARRANGEMENTS ALREADY MADE)**

Complete **SECTION A** *AND* **SECTION C.1**

SECTION A

PATIENT INFORMATION

LAST NAME: ____________________ FIRST NAME: ___________ MIDDLE: __________

MRN #: ______________ DOB: ________________ INSTITUTE: __________________

TRANSPORT INFORMATION

DATE: _________ **TIME:** ________ **REASON FOR TRANSPORT:** _____________________

☐ BLS (Basic Life Support) ☐ ROUND TRIP

☐ ALS (Advanced Life Support) ☐ ONE-WAY

☐ GROUND ☐ AIR AMBULANCE ☐ AMBULETTE/WHEELCHAIR VAN AMBULANCE

☐ IF URGENT/EMERGENT (check one)

◊ Children's Hospital ◊ Suburban Hospital

◊ Washington Hospital Center ◊ Other: __________________

PICK-UP LOCATION ☐ NIH CC ☐ OUTSIDE HEALTHCARE FACILITY ☐ HOME

FACILITY NAME: ____________________________________ BLDG: _____ UNIT#: _____

ADDRESS: ____

CITY: _____________________ STATE: ________________ ZIP CODE: ___________

PHYSICIAN: ___________________________________ PHONE #: ___________________

POINT OF CONTACT: ____________________________PHONE #: ___________________

DESTINATION ☐ NIHCC ☐ OUTSIDE HEALTHCARE FACILITY ☐ HOME

FACILITY NAME: ____________________________________ BLDG: _____ UNIT#: _____

ADDRESS: ____

CITY: _____________________ STATE: ________________ ZIP CODE: ____________

PHYSICIAN: ___________________________________ PHONE #: __________________

POINT OF CONTACT: ________________________________PHONE #: _____________________

SECTION B

COMPLETE ***ONLY*** *IF ADMISSIONS WILL MAKE ARRANGEMENTS*

PATIENT INFORMATION

HOME ADDRESS: ____

CITY: _____________________ STATE: __________________ ZIP CODE: ____________

(IF PICK-UP LOCATION OR DESTINATION IS A HOME ADDRESS: # OF STAIRS __________)

TELEPHONE NUMBER: ____

EMERGENCY CONTACT: NAME/RELATIONSHIP ____

TELEPHONE NUMBER: ____

PASSENGER(S) IN ADDITION TO PATIENT: ____

PIECES OF LUGGAGE **(IF AIR TRANSPORT):** _________

CLINICAL INFORMATION

HEIGHT: _____________ WEIGHT (KG): ___________

OXYGEN: ☐ NO ☐ YES IF YES, # LITERS ___________

IV REQUIRED DURING TRANSPORT: ☐ NO ☐ YES

IF YES, IV FLUIDS/ MEDICATIONS REQUIRED DURING TRANSPORT: (describe)

____

____

____

MONITOR(S) (EX. CARDIAC): ☐ NO ☐ YES TYPE(S) _________________________________

DOCUMENTATION

DOCUMENTION REQUIRED TO GO WITH PATIENT PER CARE TEAM: ☐ YES **(compiled by care team)** ☐ NO

☐ Transfer/Accept Note - Progress Note ☐ X-ray films ☐ X-ray report ☐ Labs ☐

DNR STATUS: ☐ NO ☐ YES

☐ IF YES, COPY OF PHYSICIAN'S DNR ORDER FROM CRIS

OTHER DOCUMENTS AMBULANCE COMPANY MAY REQUEST:

☐ MEDICAL/PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (MOLST/POLST) FORM

☐ OTHER: ____

PAYMENT INFORMATION

SELECT PAYMENT TYPE

1.☐ PRIMARY INSURANCE: _______________________ POLICY #:____________GROUP #:________

SECONDARY INSURANCE: _____________________POLICY #:____________GROUP #: _______

☐ PHYSICIAN CERTIFICATION STATEMENT (PCS)

INSURANCE COMPANY PRE-AUTHORIZED TRIP: ☐ YES ☐ NO

AUTHORIZATION NUMBER: ________________ INFORMED BY: _______________________

2.☐ AUTHORIZATION FOR OUTSIDE MEDICAL SERVICES (NIH-2541): I/C__________ CAN___________

NOTE: 2541 REQUIRED TO ARRANGE SERVICE IF NOT COMPLETED, REASON AND EXPECTED DATE FOR SUBMISSION BY I/C ____

3.☐ SELF PAY: NAME OF CARDHOLDER: ______________________________________

CREDIT CARD NAME: ________________________ CREDIT CARD #: ______________________
EXPIRATION DATE: _______________________
TELEPHONE NUMBER: _____________________________________

THE FOLLOWING SECTIONS ARE COMPLETED BY THE ADMISSIONS STAFF
(Exception: C.1 to be completed for notification of ambulance transports)

SECTION C

C.1 AMBULANCE COMPANY INFORMATION

AMBULANCE COMPANY NAME: ____
CONTACT PERSON: ____________________________ PHONE #: ______________________________

C.2 COST INFORMATION

BASE RATE: ____________ MILEAGE: _________________ PRICE PER MILE: _______________

ESTIMATED TOTAL COST: ________________________

*****IF ESTIMATED COST $5,000 OR GREATER, YOU NEED TO OBTAIN 3 PRICE QUOTES*****

C.3 PRICE QUOTES FOR AMOUNT $5,000 AND GREATER

SELECT COMPANY PROVIDING THE TRANSPORT:

☐ (1) COMPANY NAME: _____________________ PERSON PROVIDING QUOTE: _______________
ESTIMATED COST: ______________________

☐ (2) COMPANY NAME: _____________________ PERSON PROVIDING QUOTE: _______________
ESTIMATED COST: ______________________

☐ (3) COMPANY NAME: _____________________ PERSON PROVIDING QUOTE: _______________
ESTIMATED COST: ______________________

*****IF COMPANY SELECTED IS NOT THE LOWEST COST, SELECT REASON *****

☐ UNABLE TO PROVIDE TRANSPORT IN TIME REQUIRED
☐ UNABLE TO OBTAIN RATES FROM OTHER COMPANIES
☐ OTHER (EXPLAIN): ____

C.4 PERSON ARRANGING TRANSPORT

LAST NAME: ____________________________ FIRST NAME: ______________________________

DATE: ______________________ TIME: ________________PHONE: ____________________________

NIH POLICE EMERGENCY CONTROL CENTER (ECC) NOTIFICATION

NOTIFY THE NIH POLICE EMERGENCY CONTROL CENTER (ECC)

301-496-5685

ECC PERSON NOTIFIED: _______________________________

DATE/TIME OF NOTIFICATION: _________________________

NIH ENTRANCE TO USE

(PLEASE TELL AMBULANCE COMPANY THE ENTRANCE NAME, STREET AND GPS)

☐ WEST DRIVE ENTRANCE ON CEDAR LANE AND WEST DRIVE **(GPS 5300 WEST CEDAR LANE)**

** WEST DRIVE IS PREFERRED ENTRANCE 6 AM – 10 PM 7 DAYS A WEEK**

☐ CVIF (COMMERCIAL VEHICLE) ENTRANCE ON ROCKVILLE PIKE **(GPS 9100 ROCKVILLE PIKE)**

AMBULANCE COMPANY INFORMED OF GATE TO USE: ☐ YES ☐ NO

NAME OF ADMISSIONS ASSISTANT: ____

TRANSPORT DETAILS

DATE TRANSPORT OCCURRED: ________________TIME TRANSPORT OCCURRED: ________________