Non-Emergency Patient Transport Booking Form

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Please ensure the area code is included when using the fax number.
As fax can sometimes be unreliable due to aging technology, please call us to confirm after sending a booking form via fax or email.

St John

Booking Facility	Contact Name	Contact Phone Number	Contact Fax Number

Pick Up Day	Pick Up Date	Pick Up Time	Appointment Time

Authorising Medical Practitioner (* This must be signed/authorised ***)**

Name: Dr ..... Position: .....

Signed: .....

Pick Up Location (Include Full Address)	Ward / Dept

Destination (Include Full Address)	Ward / Dept

Destination Contact Number

Patient Surname	Patient Given Name(s)

Date of Birth	DD / MM / YYYY	Sex	Male / Female

Presenting Medical Condition (include any other relevant medical history)

Purpose of trip:	Responsible Billing Party:
❑ Admit / Discharge ❑ Inter-Hospital Transfer ❑ Outpatient Appointment ❑ Day Surgery ❑ Return Nursing Home / Residence ❑ Other:	❑ Hospital Direct ❑ Other (please provide details below)
Special Requirements:	**Equipment / Luggage:**
❑ Oxygen: ..... Litres per minute (LPM) ❑ IV Insitu – Contents: ..... ❑ Graseby Pump – Contents ..... ❑ Suction ❑ Other:	❑ Luggage ❑ Walking Frame ❑ Aids / Appliances ❑ Other: .....
Return Trip Required?	**Medical Escort / Family Member:**
❑ Yes • Estimated time: ..... ❑ No	❑ Nurse Escort ❑ Doctor Escort ❑ Family Member(s): ..... (max. 2)
Patient Weight (kg)	**Signature of Person Completing Form**