COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

Patient Transport for Procedure or Diagnostic/Test Services

Name of Patient: _____ Date of Transport: _____/_____/_____

Diagnostic/Test or Procedure: _____

Destination Facility: _____ Department: _____

Diagnostic/Test or Procedure Time: _____:_____ am/pm Transport Name:_____

Transport Mode: □ W/C Van □ Stretcher Van □ ALS Ambulance □ Private Vehicle

Equipment Needs: □ O2 □ Mechanical/Respiratory Support Devices □ IV Pump □ Other _____

Transport Consent

I acknowledge that my medical condition has been evaluated and explained to me by the Medical Provider or other qualified medical person(s), who has recommended that I be transported to _____ (facility) for the purpose of _____ and then return to Mangum Regional Medical Center. The potential benefits and potential risks associated with transport, and the probable risks of not being transported have been explained to me and I fully understand them. The benefits include the receipt of specialized services and continuity of care. The risks of transport or refusing consent to transport may include deterioration related to transport (e.g., accident, time delay), deterioration in condition (e.g., death, complications, permanent disability). With this knowledge and understanding, I agree and consent to be transported.

_____

Signature of Patient or Patient Representative

_____

Relationship to Patient

_____ _____/_____/_____ _____:_____

Witness Signature ***Date*** ***Time***