AUTHORIZATION TO TRANSPORT

Patient's Name	
Parent/Guardian Name	
Address	
Home Phone Number	
Cell Phone Number	
Work Phone Number	

Special Needs: _____

Behaviors: _____

Does the patient have seizures? _____ If yes what are the signs that should alert us to a seizure?

_____

What would you like done in case of an emergency? i.e. seizure, vomiting, etc.

_____

_____

Is patient in a wheelchair • Yes • No

Does patient need: **Car Seat** • Yes • No **Booster Seat** • Yes • No

This Request is for: ☐ Pick Up ☐ Drop Off ☐ Both

Pick Up	Place	
	Address	
	Phone Number	
	Contact Person	
	Special Instructions	
Drop Off	Place	
	Address	
	Phone Number	
	Contact Person	
	Special Instructions	

The undersigned hereby authorizes Comprehensive Rehab to transport to and from its facilities, the following patient _____. This authorization is effective for 12 months after the date is signed. I understand that I may revoke this authorization at any time by giving written notice to the party or institution relying upon it, and I further hereby relieve the party or institution relying upon this authorization from any liability in connection with the transfer of the child from the party or institution to Comprehensive Rehab for purposes of transporting the child to and from the patient's Medical appointment with Comprehensive Rehab.

A photocopy or exact reproduction of this signed authorization will have the same force and effect as this original.

Signature of patient or patient's caregiver (if age 18 or over) _____

Signature of parent or legal guardian (if under the age of 18) _____

Date of signing: _____

TRANSPORTATION INQUIRY FORM

Date:_____ Patient's Name:_____

Criteria

Reason for transportation request:_____

_____

_____

_____

_____

☐One time only request ☐As needed ☐Weekly appointments

Please mark what other transportation options you have explored:

☐School bus ***yes*** or ***no*** if no why:_____

☐Public transportation ***yes*** or ***no***, if no why:_____

☐Caregiver ***yes*** or ***no,*** if no why:_____

☐Paratransit ***yes*** or ***no***, if no why:_____

☐Respite Workers ***yes*** or ***no***, if no why:_____

☐Other_____ ***yes*** or ***no***, if no why:_____

Distance in miles from clinic to pick up/drop off location:_____

Please circle below the day(s) that you are requesting Comprehensive Rehab to provide transportation and whether it is for pick up or drop off.

Monday		Tuesday		Wednesday		Thursday		Friday	
Pick up	Drop off	Pick up	Drop off	Pick up	Drop off	Pick up	Drop off	Pick up	Drop off

If Comprehensive Rehab will be providing transportation for your child, please note that you must be available to walk your child to and from the vehicle. Also, if you fail to contact Comprehensive Rehab in the event that you need to cancel, you may no longer be eligible for this complimentary service. If we transport your child during school hours and school is canceled for any reason, you must contact our office to let us know of the new drop off and/or pick up location(s).

_____ _____ _____

Signature of patient/parent or guardian Date Relationship to patient

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Internal use only

☐Transportation service is recommended ☐Transportation service is not recommended

_____ _____

Transportation Committee Member signature Date

Date patient/parent or guardian was contacted _____ by whom:_____

Date