STRETCHER ASSESSMENT FORM for Standing Orders

****Stretcher Vans **DO NOT** provide personnel for medical monitoring or assistance****

Trip Date: ___________________ **Appointment Time:** ___________________

Pick-Up Time _____: ______ **Return Time** ____: ____ **Will an escort accompany? Yes / No**

Require Ambulance Service? Yes / No

Special Accommodations: ____

Participant's Information

Name:____

MO HealthNet #: ______________________________**Date of Birth:** _____________________**Weight:** _____________

Please check the appropriate statement for the participant needing Non-Emergency Transportation. All questions must be completed for request to be considered and processed.

1.) Is the transportation to an Emergency Room? Yes___ No___

2.) Is the participant stable? Yes___ No___

3.) Is the participant experiencing a sudden change in their Medical Condition? Yes___ No___
If yes, please explain: ____

4.) Does the participant require oxygen during transport? Yes___ No___
Note: Oxygen is approved **ONLY** as long as it is self-administered and the participant has his or her own oxygen and be able to control the oxygen flow.

5.) Does the participant require any type of medical care or observation during transport? Yes___ No___

6.) Does the participant have an I.V.? Yes___ No___
Note: IV's **CANNOT** be administered in a stretcher van.

7.) Does the participant have a feeding tube (G-tube) that will be clamped during transport? Yes___ No___

8.) Will the participant need any medications administered during transport? Yes___ No___
Note: Stretcher attendants are not allowed to administer medication. A person who is heavily sedated and cannot care for him or herself, or has an altered level of consciousness as a result of medication, cannot be transported by a stretcher van.

Please describe participants' condition: ____

I, the **certified professional named above**, acknowledge that I realize that transportation should only be provided to treatments which MO HealthNet pays for and hereby declare, under potential penalty of MO HealthNet fraud that to the best of my knowledge and belief the above-entered information is accurate.

Certified Physician/ Nurse Signature: ____ **Date:** ____________________

Please Print Name: ____

Please fax this form to the LogistiCare Facility Department at 1-866-269-8875