Region 1 South
Voluntary Transportation System

Serviced by

Illinois Patient Transport
a division of Advanced Medical Transport of Central Illinois
Behavioral Health Services

To request transportation call 877-745-8367 or 309-999-4040
AND
Fax the front and back of this form completed to: 309-494-6227

EDA – Eligibility Disposition and Assessment Evaluator (complete front and back)

Name _____ Phone _____

Requests a voluntary transport to (check one);

- ☐ CHIPS – Community Hospital Inpatient Psychiatric Services
- ☐ DASA – Substance Abuse Residential Crisis Stabilization
- ☐ Mental Health Crisis Residential
- ☐ John J Madden Mental Health Center

Authorization Number _____ **Date of Service** _____

Patient Information

Patient Name: _____ Age: _____ DOB: _____ Gender: M F

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Emergency Contact: _____

SSN: _____ Emergency Contact Phone: (____) _____

Pre-transport Risk Assessment

1. Do physical limitations prohibit transport by car; ambulatory, weight, or other?	YES	NO
2. Is the patient a juvenile? *(IPT does not transport juveniles)*	YES	NO
3. Are there identified complicating medical conditions with potential for difficulty en route?	YES	NO
4. Is there a potential for drug or alcohol withdrawal en route?	YES	NO
5. Is there a history of violence or assaultive behavior?	YES	NO
6. Has the patient been searched for contraband?	YES	NO
7. Was there use of PRN medications for agitation with this ER admission?	YES	NO
8. Is the patient aware of the voluntary transport and the location of treatment services?	YES	NO
9. Has the patient been accepted at the receiving facility?	YES	NO

Transferring Facility | County of Originating Facility:_____

Transferring Facility:_____ Room:_____ Phone: (____)_____

Address:_____ City:_____ State:_____ Zip: _____

ER Supervisor/Contact Person:_____ Contact Phone: (____)_____

Destination Facility | County of Destination Facility:_____

Destination Facility:_____ Room:_____ Phone: (____)_____

Address:_____ City:_____ State:_____ Zip: _____

Contact Person:_____ Contact Phone: (____)_____

To be completed by the patient

I am aware of the treatment opportunity at the destination facility above. I understand and accept transportation directly to the destination facility.

Name _____ Date _____

Transferring Facility Sign Off

Patient Picked up:

Date: _____

Time: _____

Signature: _____

Title: _____

Destination Facility Sign Off

Patient Arrived:

Date: _____

Time: _____

Signature: _____

Title: _____