Inland Empire Health Plan

TRANSPORTATION REQUEST FORM (HOSPITAL)

IEHP Member ID: _____ Discharge Date & Time: _____

Member Name: _____ * Height: _____ Weight: _____

Trach to Ventilator: ☐ YES ☐ NO Suctioning: ☐ Deep ☐ Mild ☐ Shallow
Trach to Oxygen: ☐ YES ☐ NO Liter Flow: _____ FIO_2: _____
Trach to Room Air: ☐ YES ☐ NO Comments: _____
Oxygen: ☐ YES ☐ NO _____

**Height and weight are required if Member is transported via wheelchair or gurney.*

COVID-19 TEST DATA *(not required)*

Test Administered: ☐ YES ☐ NO ☐ Unknown Test Date: _____

Test Results: ☐ Covid-19 Positive ☐ Covid-19 Negative ☐ Unknown Result Date: _____

TRANSPORTATION FROM

Facility & Treating Physician: _____ Room #: _____

Address: _____

City: _____ Zip code: _____

Contact Person: _____ Phone: _____

TRANSPORTATION TO

Facility (if applicable) : _____ Room #: _____

Receiving Physician/Caregiver: _____

Address: _____

City: _____ Zip code: _____

Contact Person: _____ Phone: _____

TRANSPORTATION BY

☐ Ambulatory
☐ Wheelchair: ☐ Standard ☐ Bariatric/Wide ☐ Electric ☐ Vendor to provide wheelchair

*(*Note: Gurney will be provided when no wheelchair is available)*

☐ Gurney: ☐ Bariatric ☐ ALS ☐ BLS ☐ CCT (only) Stair Support needed? Y☐ N☐
Attendant/Caregiver ☐ If yes, how many stairs? _____

Sending Physician: _____ Receiving Physician/Caregiver: _____

Please fax request to IEHP Transportation Department (909) 912-1049

P.O BOX 1800 Rancho Cucamonga CA 91729-1800
Phone: (951) 374-3441 Fax: (909) 912-1049
Visit our web site at: www.iehp.org
A Public Entity

Revised 01/24/24