

## REQUEST OF APPROVAL FOR PATIENT TRANSPORTATION FOR MANITOBA TREATMENT

### REFERRAL/PATIENT INFORMATION

Patient's Name: _____	
Community: _____	Treaty Number: _____
Date of Birth: _____	Sex:     Male     Female
MHSC# _____	PHIN# _____
Referred by: _____	Date: _____
Referred to: _____	
Province: _____	
Treatment Centre Phone: _____	NNADAP Funded?     Yes     No
Intake Appointment:     From _____	To _____

### TRANSPORTATION/REQUIRED SERVICE

Mode of Transportation
<input type="checkbox"/> Bus <input type="checkbox"/> Private Vehicle  <input type="checkbox"/> Other     Explain _____ _____ _____ _____
Escort <input type="checkbox"/> Yes <input type="checkbox"/> No If yes explain _____ _____ _____

Travel Reimbursement
Warrant: <input type="checkbox"/> Bus <input type="checkbox"/> Other     Explain: _____
Private Vehicle: From _____ To _____ Driver: _____ Km.
Bus Fare Equivalency: From _____ To _____ Fare: _____

Signature of Nurse: _____	Health Facility: _____
I _____ consent to release of medical information to the Patient Transportation Coordination Unit as to the condition being treated of procedure being accessed this medical trip and verification of attendance at me appointment.	
<i>CONFIRMATION OF ATTENDANCE AT APPOINTMENT:</i>	
Signature and Title ✍ _____	

### MEDICAL TRANSPORTATION CLAIM:(original receipts must be attached)

Travel: \$ _____	Meals: \$ _____ <small>(Where applicable, with receipt)</small>	Accommodations: \$ _____ <small>(Where applicable, with receipt)</small>
TOTAL CLAIM:\$ _____		
To be Paid to: (Name and Address) _____		