REQUEST OF APPROVAL FOR PATIENT TRANSPORTATION FOR OUT OF PROVINCE 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

☐ Bus ☐ Private Vehicle

☐ Other Explain ______________________________

Escort ☐ Yes ☐ No
If yes explain ______________________________

Travel Reimbursement

Warrant: ☐ Bus ☐ 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.

CONFIRMATION OF ATTENDANCE AT APPOINTMENT:

Signature and Title ✍ ______________________________

MEDICAL TRANSPORTATION CLAIM:(original receipts must be attached)

Travel: $	Meals: $ (Where applicable, with receipt)	Accommodations: $ (Where applicable, with receipt)

TOTAL CLAIM:$

To be Paid to: (Name and Address)