

LOS ANGELES COUNTY  
DEPARTMENT OF MENTAL HEALTH

REQUEST TO TRANSPORT A SHORT-DOYLE (01) PATIENT OUT OF STATE  
(Please Type or Print)

Date of Request: \_\_\_\_\_ Person Requesting: \_\_\_\_\_

Name Title Phone

Patient's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ D/O/B: \_\_\_\_\_

Patient's Location: \_\_\_\_\_  
Hospital Ward Phone

Conservatee: Yes \_\_\_\_\_ No \_\_\_\_\_ Court Ordered: Yes \_\_\_\_\_ No \_\_\_\_\_

Legal Residence: \_\_\_\_\_  
City State

Is Patient a Danger to Self of Others? Yes \_\_\_\_\_ No \_\_\_\_\_

Physical Condition: Fully Ambulatory \_\_\_\_\_ Limitations (Specify) \_\_\_\_\_

Requires: Stretcher \_\_\_\_\_ Wheelchair \_\_\_\_\_ Feeding \_\_\_\_\_ Medication \_\_\_\_\_

If additional services or equipment are to be required, please identify: \_\_\_\_\_

Escort Required: Medical \_\_\_\_\_ Lay Person \_\_\_\_\_

Escort's Name & Title: \_\_\_\_\_  
Phone

Patient Can Safely Make Trip to: \_\_\_\_\_  
Destination

Patient Can Pay: All Expenses \_\_\_\_\_ Ticket \_\_\_\_\_ Meals \_\_\_\_\_ Nothing \_\_\_\_\_

Psychiatrist Approving Travel Plan \_\_\_\_\_  
(Please Type or Print) Name Title Location

Approving Psychiatrist's Signature

NOTE: A SIGNED AND DATED PATIENT REQUEST AND CONTINUING CARE PLAN (USE MH FORM #1944 OR REASONABLE SUBSTITUTION) MUST ACCOMPANY THIS REQUEST WHEN SUBMITTED. PATIENT SIGNED REQUEST OR AGREEMENT TO BE TRANSPORTED MUST ACCOMPANY THIS FORM.

Identify receiving facility, contact person, address, phone, etc. (Comments)

M.H. Headquarter Use Only

Guardian's Signature Date

Approving M.D. Signature Date

Approving M.H. Administrator Date