

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