IntelliRide by transdev

Level of Service
Medical Recommendation Form

Dear Medical Professional:

IntelliRide has received a request for transportation for one of your patients. Please fill out this Level of Service Medical Recommendation Form completely and provide any supporting information as needed. This form will be used to determine the patient's most appropriate mode of transportation based on his or her functional abilities and limitations

Note: This form is valid for one year from the date signed or the date indicated below

Patient Info	First Name:	Last Name:	Date of Birth:	
	Medicaid #:	Phone #		
	Address:	City	State:	Zip:
Medical Info	Diagnosis that supports transportation limitation, or ICD-10 code. Must Provide. Recent hospitalizations		Diagnosis is ☐ Temp (through date) ☐ Permanent	
Home Life	☐ Lives alone or w/ family/friends ☐ Nurising facility ☐ Group Home ☐ Residential Rehab facility			
	comments			
Physical Abilities and Equipment	Can patient ambulate independently Yes No Max dist			
	Does Patient use any of the following assistive devices? Cane ☐ Svc Animal ☐ Walker ☐ Port Oxygen ☐ Crutches ☐ Wheelchair ☐ Electric wheelchair ☐ XL Wheelchair*** ☐		*** Note: XL WC is wider than 20" across or combined weight of WC & patient exceeds 350lbs	
	If XL Wheelchair is selected, please complete the following Weight of WC Weight of Patient Width of Wheelchair			
	Does the patient require an escort to travel with			
	Can patient self propel in wheelchair? Can patient self transfer from wheelchair?			
	Do environmental factors like heat or cold affec the patient's mobility Preferred Provider?			
Cognitive Abilities	Does the patient have problems with any of the following? If yes, please rate level of difficulty. 1 being mild to 5 being severe			
	Alertness No Yes 1 2 3 4 5		additional comments	
	Memory Issues No Yes 1 2 3 4 5			
	Confusion No Yes 1 2 3 4 5			
Sensory Abilities	Vision Cataracts? Legally blind?			
	Speech & Hearing Deaf? Able to communicate needs?			
Medical Professional Info	Printed name and title:		Phone Number	
	Signature*		NPI #	

.*By signing, the medical professional certifies and attests that each statement is accurate and true to the best of their knowledge.
Please allow 2 business days for this form to be processed

Please send completed form to: Fax (720) 302.0106 | Email: us.coclinicalcoordinator@transdev.com

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