transdev
the mobility company

Level of Service
MEDICAL RECOMMENDATION FORM

Dear Medical Professional:

Transdev 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 #:	Address:		
	City:	State:	Zip:	Phone #:
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 ☐Nursing facility ☐Group Home ☐Residential Rehab facility			
	Comments:			
Physical Abilities and Equipment	Can patient ambulate independently? Max distance:			
	Does Patient use any of the following assistive devices? *** **Note: XL WC is wider than 20" across or combined weight of WC & patient exceeds 350lbs.** Cane ☐ Svc Animal ☐ Walker ☐ Port Oxygen ☐ Crutches ☐ Wheelchair ☐ Electric Wheelchair ☐ XL Wheelchair*** ☐			
	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 affect 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 Memory Issues Confusion			
	Additional comments:			
Sensory Abilities	Vision Cataracts? Legally blind?			
	Speech & Hearing Deaf? Able to communicate needs?			
Medical Professional Info	Printed name and title: Phone #: 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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