

## Stretcher Transportation Written Order

Date yyyy / mm / dd

Service Number

Transport Number

### A. Pick up Location

### B. Destination

### C. Identifying Information – Individual being transported

Last Name

First Name

PHIN

Address

City

Province

Postal Code

### D. Special Considerations for Individual being transported

Oxygen?

☐ Yes ☐ No

Specify

Neonatal Team?

☐ Yes ☐ No

Specify

Infection Control Precautions?

☐ Yes ☐ No

Specify

Other?

☐ Yes ☐ No

Specify

### E. Transport Approved by ( *must be signed by a physician, nurse or recognized care provider for the individual* )

Last Name

First Name

Primary Contact Telephone Number

Signature

Date