

LogistiCare Checklist for Scheduling Hospital Discharges

Patient Information

Medicaid ID Number	
First Name	
Last Name	
Date of Birth	
Home Address Street	
Home Address City	
Home Address ZIP	
Hospital Name	
Room # & Bed #	
Nurse's Station Telephone Number	
Date and Time Patient Will be Ready for Discharge	
Is the patient traveling alone?	

Mode of Transportation Requested

Livery	
Ambulette/Ambulatory	
Ambulette/Wheelchair	
Stretcher Van	
Basic Life Support Ambulance	
Advanced Life Support Ambulance	

Transportation Vendor

Preferred Transportation Vendor Name	
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Trip Information

Destination Address Street	
Destination Apartment Number	
Destination Address City	
Destination Address ZIP	
Number of stairs at destination	
Does the destination have a ramp?	
Does the destination have a working elevator?	

If patient is **WHEELCHAIR-BOUND**:

Is wheelchair electric?	
Is wheelchair manual?	
What is the approximate weight of the patient?	

If patient requires **AMBULANCE**:

What is the approximate weight of the patient?	
What type of medical monitoring does the patient need en route?	
Does the patient have any special needs during transport?	