McLAREN FLINT
Outpatient Diagnostic Imaging

TRANSPORTING FROM CARE FACILITY

To be completed by Nursing Facility

Name of Originating Facility: _____

Patient's Name: _____

This test CANNOT be carried out without a physicians order.

SIGNED Physician's Order Attached: Yes ____ No ____

Patient Accompanied By: _____

Transport Mode: Stretcher: ____ Wheelchair:____ Walk: ____

Is Patient a fall risk? Yes____ No____

Lines:	**O_2:**	**Monitor:**	**Neuro:**	**IV:**
AV Fistula: ____	Yes: ____	Yes: ____	Alert: ____	Yes: ____
VAS Cath: ____	No: ____	No: ____	Oriented: ____	No: ____
NGT/OGT: ____			Confused: ____	
Foley: ____			Lethargic: ____	
CVC: ____			Deaf: ____	
PICC: ____			Blind: ____	

Code Status:

Full Code: ____

No Code: ____

Patient Allergies: _____

_____

Any Belongings with Patient upon arrival: _____

_____

Any Important Information regarding patient: _____

_____

_____

To be completed by Diagnostic Imaging Center

POST PROCEDURE REPORT-OUT

Date/Time: _____ Procedure: _____ Tech Initials: _____

Report called to: _____

Patient disposition following test: _____

_____

TRANSPORTING FROM CARE FACILITY

17849 Rev. 5/13

870b

PT.

MR.#/P.M.

DR.