



DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

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PATIENT REQUEST FOR TRANSPORTATION

Los Angeles County
Department of Mental Health
510 South Vermont Avenue
Los Angeles, CA 90020

Attention: Patient Transportation Coordinator

Re: _____
Patient Name (Print)

I am requesting transportation to my home state of residence

City and State

- a. I understand that is a voluntary plan (or plan of Conservatorship Court).
- b. I understand that I will be taken to a designated Mental Health facility for evaluation and possible follow-up care upon arrival at destination.
- c. I understand that family members may be involved in the plan for living arrangements and follow-up care.
- d. I understand that this is a one-time only service.

I have been informed and involved in the plans for my transportation.

Patient's Signature

Date

Discharge Social Worker