

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

REQUEST TO TRANSPORT A SHORT-DOYLE (01) PATIENT OUT OF STATE
(Please Type or Print)

Date of Request: _____ Person Requesting: _____
Name Title Phone

Patient's Name: _____ Sex: _____ D/O/B: _____

Patient's Location: _____
Hospital Ward Phone

Conservatee: Yes ☐ No ☐ Court Ordered: Yes ☐ No ☐

Legal Residence: _____
City State

Is Patient a Danger to Self or Others? Yes ☐ No ☐

Physical Condition: Fully Ambulatory ☐ Limitations (Specify) _____

Requires: Stretcher ☐ Wheelchair ☐ Feeding ☐ Medication ☐

If additional services or equipment are to be required, please identify: _____

Escort Required: Medical ☐ Lay Person ☐

Escort's Name & Title: _____
Phone

Patient Can Safely Make Trip to: _____

Patient Can Pay: All Expenses ☐ Ticket ☐ Meals ☐ Destination Nothing ☐

Psychiatrist Approving Travel Plan _____
(Please Type or Print) Name Title Location

Approving Psychiatrist's Signature

NOTE: A SIGNED AND DATED PATIENT REQUEST AND CONTINUING CARE PLAN (USE MH FORM #1944 OR REASONABLE SUBSTITUTION) MUST ACCOMPANY THIS REQUEST WHEN SUBMITTED. PATIENT SIGNED REQUEST OR AGREEMENT TO BE TRANSPORTED MUST ACCOMPANY THIS FORM.

Identify receiving facility, contact person, address, phone, etc. (Comments)

M.H. Headquarter Use Only

Guardian's Signature

Date

Approving M.D. Signature

Date