AMBULATORY LIFT TEAM REQUEST FORM

FAX TO: (310) 267-3610

DATE OF REQUEST: _____ REQUESTOR: _____

PATIENT NAME: _____

CLINIC: _____

DATE OF APPT: _____ TIME OF APPT: _____ TIME LT NEEDED:_____

LOCATION NEEDED (circle): In clinic Curbside Other: _____

TYPE OF ASSISTANCE (circle): Car Transfer To/From exam table

To/From wheelchair / other chair Restroom Other: _____

APPROXIMATE LEVEL OF ASSISTANCE (circle): Max / Dependent Moderate

Minimal Other: _____

EQUIPMENT USED BY PATIENT (circle): Wheelchair Walker/Cane
Oxygen Other: _____

OTHER COMMENTS:

_____

_____

_____

CLINIC CONTACT NAME / NUMBER: _____

FOR LIFT TEAM USE ONLY:

Request completed by: _____

Not completed? Reason: _____