

Patient Transfer Center – Arizona

PHONE: (866) 829-8387 • FAX: (480) 358-6362



Date: _____ Time: _____ DOB: _____

Last Name: _____ First Name: _____

Facility Calling/Faxing From: _____

Person Calling/Faxing: _____ Physician: _____

Patient Location: ED Inpatient Physician's Office

Call Back Number: _____

Diagnosis: _____

Secondary Diagnosis: _____

Isolation/Special Needs: _____

Type of bed requested: ICU Telemetry Med/Surg GYN Copy of Facesheet: Yes No

Primary Ins.: _____

Primary # _____ Group # _____

Secondary Ins.: _____

Secondary # _____ Group # _____

Self Pay: _____ Yes _____ No Copy of Facesheet: _____ Yes _____ No

Recent Vital Signs: _____

Abnormal Labs: _____

Notes: _____

Transportation: Ground Air BLS ACLS Company: _____