

STANDING ORDER FORM

FAX# (808) 441-5987

Agent Name: _____

Date: _____

MEMBER INFORMATION	
Member's Name:	Member ID#:
D.O.B: mm/dd/yy	Member's Phone Number:

STANDING ORDER INFORMATION							
Days	Monday <input type="checkbox"/>	Tuesday <input type="checkbox"/>	Wednesday <input type="checkbox"/>	Thursday <input type="checkbox"/>	Friday <input type="checkbox"/>	Saturday <input type="checkbox"/>	Sunday <input type="checkbox"/>
Appt. Time <small>*Please write exact time.</small>		A.M. <input type="checkbox"/>	P.M. <input type="checkbox"/>	Can the member sign the driver's log? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Return Time		A.M. <input type="checkbox"/>	P.M. <input type="checkbox"/>	Treatment Type: <input type="checkbox"/> Dialysis <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Adult Day Care <input type="checkbox"/> Mental Health <input type="checkbox"/> Other:			
Start Date	___/___/___						
End Date	___/___/___						

LEVEL OF SERVICE						
Ambulatory <input type="checkbox"/>	Wheelchair <input type="checkbox"/>	Mass Transit <input type="checkbox"/> <small>(TheBus, etc.)</small>	Paratransit <input type="checkbox"/> <small>(TheHandi-Van, etc.)</small>	Stretcher <input type="checkbox"/>	Height:	Weight:

Special Needs/ Devices: _____

MEMBER PICK UP INFORMATION	
Residence/ Facility Address:	Member's Phone Number:
City, State and Zip Code:	Instructions for the Driver:

FACILITY DROP OFF INFORMATION	
Facility Name/ Doctor:	Facility Phone Number:
Address:	City, State and Zip Code:

FACILITY/ PHYSICIAN INFORMATION	
Physician/ Case Manager requesting Standing Order:	Title:
Phone Number:	Fax Number:
Physician Signature:	Date:

FOR INTERNAL USE: [] Inserted by - Initials: _____ Date: _____

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