IntelliRide by transdev

Level of Service
Medical Recommendation Form

Dear Medical Professional:

IntelliRide has received a request for transportation for one of your patients. Please fill out this Level of Service Medical Recommendation Form completely and provide any supporting information as needed. This form will be used to determine the patient's most appropriate mode of transportation based on his or her functional abilities and limitations.

Patient Info	First Name:	Last Name:	Date of Birth:	
	Medicaid #:	Phone #:	Trip #:	
	Address:	City:	State:	Zip:
Medical Info	Diagnosis that supports transportation limitations (MUST PROVIDE):		Diagnosis is: ☐ Permanent ☐ Temporary - Through (date):	
	Recent Hospitalizations/Surgeries (MUST PROVIDE):			
Home Life	☐ Lives alone or with family/friends ☐ Nursing facility ☐ Group home ☐ Residential rehab facility Comments:			
	Number of steps at residence: _____			
Physical Abilities and Equipment	Can patient ambulate independently? ☐ Yes. (Max. Distance:_____) ☐ No			
	Does patient use any of the following assistive devices? ☐ Cane ☐ Crutches ☐ Walker ☐ Portable Oxygen ☐ Service Animal ☐ Electric Wheelchair ☐ Manual Wheelchair			
	Does patient require assistance of trained personnel for safety? ☐ Yes ☐ No			
	Can patient self propel in wheelchair? ☐ Yes ☐ No	Can patient self-transfer from wheelchair? ☐ Yes ☐ No		
	Do environmental factors like heat or cold affect the patient's mobility? ☐ Yes (please explain): ☐ No			
	Has there been a decline in functionality? ☐ Yes (please explain): ☐ No			
Cognitive Abilities	Does the patient have problems with any of the following? If yes, circle a rating for each category, with 1 being mild impairment and 5 being severe impairment. Alertness ☐ No ☐ Yes 1 2 3 4 5 Memory Issues ☐ No ☐ Yes 1 2 3 4 5 Confusion ☐ No ☐ Yes 1 2 3 4 5	Additional comments:		
	Able to remove self from unsafe situation?	☐ Yes	☐ No	
Sensory Abilities	Vision	☐ Cataracts ☐ Legally blind Comments:		
	Speech & Hearing	Deaf? ☐ Yes ☐ No	Able to communicate needs? ☐ Yes ☐ No	
Medical Professional Info	Printed Name:		Phone #:	
	Signature*:		NPI #:	

*By signing, the medical professional certifies and attests that each statement is accurate and true to the best of their knowledge.

Please allow 2 business days for this form to be processed.

Please send completed form to: Fax (720) 302.0106 | Email: us.coclinicalcoordinator@transdev.com