Ministère des Affaires sociales
Direction générale du financement
Division des services aux centres hospitaliers

DECLARATION OF TRANSPORT BY AMBULANCE

Identification

Name of person transported | Sex M ☐ F ☐

Address

Telephone number | Age | Health Insurance No.

Name of ambulance service

Permit No. | Vehicle reference No.

Co-ordinates of transport

Date of call | Time of call | Time of taking in charge | Time of arrival at H.C. | Distance travelled with transported person ____ km

Taking in charge by the carrier

☐ Public lane
☐ Private residence
☐ Public building
☐ Work premises

☐ Hospital Centre
☐ Reception Centre
☐ LCSC
☐ Other _____

ZONE OF TAKING IN CHARGE

Identification of location where taken in charge

Address | Code for establishment that takes person in charge

Destination of the transported person

Name of establishment or other | Code for receiving establishment

Transfer by an establishment

Transfer by plane ☐ | Helicopter ☐ | Ambulance ☐ | Other ☐

Name of escort | Transport one-way ☐ return ☐

Reason for transfer
1 — perinatality 2 — neo-natality 3 — for diagnosis 4 — emergency 5 — others

Amount to be paid by establishment to transfer $

Justification

Authorization of transfer

Date _____ Attending physician _____

Date _____ Director-general of H.C. or his representative _____

Date _____ Attendant's signature _____ Signature of transported person or his escort or receiver _____

Reserved for carrier

ADM-307