Pediatric Mental Health Program

TRANSPORTATION REQUEST FORM

Embassy ☐ Insurance ☐

Minor Full Name: Phone #

Address:

Pick-up location: Pick-up Phone #

Drop-off location: Drop-off Phone #

Apt date & time:

Reoccurring appointment (circle): Y or N if yes, day/time of apt:

Date of Birth:

Guardian Name: | Guardian Phone #:

Allergies:

Conditions requiring special consideration (medical/physical):

Transportation Waiver signed & on file? Y or N if yes, dated:

Therapist:

HEALTH INSURANCE INFORMATION:

Company Name: Policy #: Group #:

Additional notes:

Submit form to: Fax: (612) 416-2093 | Email: DNeiss@redlakenation.org | Questions: Danielle Neiss (651) 396-3070