ATTACHMENT F

IMPACTED HOSPITAL PROGRAM (IHP) ENROLLMENT FORM

Fax completed form to the Medical Alert Center at (562) 906-4300

IHP and PATIENT INFORMATION

EMS REPORT FORM SEQUENCE NUMBER:____

DATE ENROLLMENT FORM SUBMITTED:___________________________TIME SUBMITTED:_____________________ AM PM

EMS INCIDENT LOCATION:____
street city zip code

OR HOME ADDRESS:____
street city zip code

HOSPITAL:____

PATIENT LAST NAME:________________________________FIRST:__________________________MIDDLE INTIAL_____

SEX: MALE FEMALE DATE OF BIRTH____

DATE ADMITTED TO EMERGENCY DEPARTMENT :_______________________________TIME:__________________ AM PM

ADMIT DIAGNOSIS:____

HOSPITAL UTILIZATION REVIEW NURSE CONTACT:____

TELEPHONE:_______________________FAX:______________________________

PATIENT DISPOSITION

Check appropriate box below

ADMITTED TO HOSPITAL

REQUEST TRANSFER VIA MAC? (attach MAC pack)

YES NO

TREATED AND RELEASED FROM ED

TRANSFERRED TO OTHER FACILITY:____

PATIENT EXPIRED

OTHER:____

EMERGENCY MEDICAL SERVICES AGENCY USE ONLY

PTIS NUMBER:______________________ MAC COORDINATOR__________________________

INITIATE MAC TRANSFER PRIMARY MEDICAL SERVICE _________________________