

**Massachusetts**  
**STANDING ORDER REQUEST FORM**  
 (For facility use only)



<b>FACILITY PHONE: (855)-483-6530</b>		<b>FACILITY FAX: (855) 864-0954</b>	
Ordered By		Phone	
Title		Fax	
Member Name			Date of Birth
Member ID #			Insurance Type
Treatment Days	<input type="checkbox"/> MON	<input type="checkbox"/> TUES	<input type="checkbox"/> WED
	<input type="checkbox"/> THURS	<input type="checkbox"/> FRI	<input type="checkbox"/> SAT
	<input type="checkbox"/> SUN		
Appoint. Time	Arrival Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM		Return Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<b>Level of Service (required)</b>			
<input type="checkbox"/> AMBULATORY	<input type="checkbox"/> WHEELCHAIR: Weight: _____ Height: _____ Stairs: _____ <input type="checkbox"/> DOOR – DOOR for selected LOS Reason _____ Any other special needs or directions: _____		
<b>ALS , BLS, and Stretcher</b>			
<input type="checkbox"/> ALS <input type="checkbox"/> BLS <input type="checkbox"/> Non-Medical Stretcher <input type="checkbox"/> Other medical needs: _____		<input type="checkbox"/> Cardiac Monitor <input type="checkbox"/> Oxygen - LPM _____ <input type="checkbox"/> IV:Type _____ Bariatric: Weight: _____ Height: _____	
Escort traveling with member <input type="checkbox"/> YES <input type="checkbox"/> NO			
Can member sign driver log <input type="checkbox"/> YES <input type="checkbox"/> NO		Start Date: _____ End Date: _____	
If member cannot sign, reason: _____		(on-going if not checked)	
<b>Treatment Type</b>			
<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Mental Health/Counseling	<input type="checkbox"/> Wound Care	
<input type="checkbox"/> Chemo/Radiation	<input type="checkbox"/> Physical Rehabilitation	Other: Specify: _____	
<input type="checkbox"/> Dialysis	<input type="checkbox"/> Pain Management		
<b>Holiday Schedule (for facility attending)</b>			
New Year's Eve	<input type="checkbox"/> Open	<input type="checkbox"/> Closed	<input type="checkbox"/> Schedule Change
New Year's Day	<input type="checkbox"/> Open	<input type="checkbox"/> Closed	<input type="checkbox"/> Schedule Change
Martin Luther King	<input type="checkbox"/> Open	<input type="checkbox"/> Closed	<input type="checkbox"/> Schedule Change
Presidents Day	<input type="checkbox"/> Open	<input type="checkbox"/> Closed	<input type="checkbox"/> Schedule Change
Good Friday	<input type="checkbox"/> Open	<input type="checkbox"/> Closed	<input type="checkbox"/> Schedule Change
Patriots Day	<input type="checkbox"/> Open	<input type="checkbox"/> Closed	<input type="checkbox"/> Schedule Change
Memorial Day	<input type="checkbox"/> Open	<input type="checkbox"/> Closed	<input type="checkbox"/> Schedule Change
July 4 <sup>th</sup>	<input type="checkbox"/> Open	<input type="checkbox"/> Closed	<input type="checkbox"/> Schedule Change
Labor Day	<input type="checkbox"/> Open	<input type="checkbox"/> Closed	<input type="checkbox"/> Schedule Change
Columbus Day	<input type="checkbox"/> Open	<input type="checkbox"/> Closed	<input type="checkbox"/> Schedule Change
Veterans Day	<input type="checkbox"/> Open	<input type="checkbox"/> Closed	<input type="checkbox"/> Schedule Change
Thanksgiving	<input type="checkbox"/> Open	<input type="checkbox"/> Closed	<input type="checkbox"/> Schedule Change
Day after Thanksgiving	<input type="checkbox"/> Open	<input type="checkbox"/> Closed	<input type="checkbox"/> Schedule Change
Christmas Eve	<input type="checkbox"/> Open	<input type="checkbox"/> Closed	<input type="checkbox"/> Schedule Change
Christmas	<input type="checkbox"/> Open	<input type="checkbox"/> Closed	<input type="checkbox"/> Schedule Change

"Caution: This information contains confidential and proprietary trade secrets, the release of which could cause competitive harm. It is not subject to disclosure under any freedom of information act or open records act law or regulation. Do not further disclose."

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Pick-Up Info				
Residence/Complex Name/Facility				
Address			Apt. / Room #	
City	State		Zip	
Phone	Alternate Phone			
Drop-Off Info				
Facility / Complex Name				
Address			Apt. / Room #	
City	State		Zip	
MD:	Department:			
Phone	Alternate Phone			
Previous Service issues/ Special needs:  _____ _____ _____ _____ _____ _____ _____ Preferred Transportation Provider: _____		Process for weather related closures:  _____ _____ _____ _____ _____ Additional information specific to this member: _____ _____ _____		

**Visit the website for facilities at <https://facility.logisticare.com> to input your own standing orders or single trip requests.**

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