

## Patient Travel Request (ITA)

1. Patient's Name: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_
2. Patient's Category (Circle One): DEP/RET/DA CIVILIAN/DOD EMPLOYEE
3. Sponsor's SSN: \_\_\_\_\_ 5. Patient's SSN: \_\_\_\_\_
4. Patient's Address: \_\_\_\_\_
6. Patient's Day Time Phone Number: \_\_\_\_\_
7. Travel Purpose: \_\_\_\_\_
8. Is this a case management issue (i.e., complex medical needs/multiple systemic issues)? Are you being managed? (Circle One): Yes( CM name: \_\_\_\_\_) / No
9. Approximate number of Requested Days (including travel): \_\_\_\_\_
10. Proceed Date: \_\_\_\_\_ Return Date: \_\_\_\_\_

Itinerary: **From: Fox Army Health Center, RSA** To (if medical appointment, include doctor's name/location): \_\_\_\_\_ **Return To: Fox Army Health Center, RSA**

(Example: **To:** Dr. Smith, Kirklin Clinic, Birmingham, AL)

11. Patient Status: (Circle One) Inpatient / Outpatient
12. Transportation Mode (Circle One): POV / Commercial Air
13. If flying Commercial, will you require a rental car? (Circle One) Yes / No
14. Copy of Referral Required Before Travel (**Must be a specialty treatment network provider**)
15. Will there be an attendant/escort(Must be authorized by primary care manager):(Circle One)Yes / No

Name of Attendant: \_\_\_\_\_ Attendant's SSN: \_\_\_\_\_

Attendant's Relationship to Traveler: \_\_\_\_\_

**If you have any questions/concerns while completing this worksheet, please contact Ms. Karyn Woods, ITA Coordinator, at (256)955-8888 Ext. 1616.**

**Privacy Act of 1974 and HIPAA are applicable when worksheet is completed.**