



Houston Ground Angels

MISSION REQUEST FORM

*****Patients under the age of 18 MUST be accompanied by a parent or adult guardian*****

Date: _____ Patient's Record No. _____ Gender: _____ Date of Birth _____

Patient's Name: _____ Weight (lbs): _____ Height: _____

Patient's Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ Work phone: _____ Fax: _____

Cell: _____ Email: _____

Primary Language Spoken: _____ If other than English, whom do we contact?

Name: _____ Phone number: _____ Cell: _____

(1000-mile limit)

Origination City: _____ Destination City: _____

Travel Date: _____ Appointment Date: _____ Time: _____

Return Date: _____ Release Time: _____

Patient's Place of Lodging: _____ Lodging Phone: _____

Requesting Facility: _____

Address: _____ City: _____ State: _____ Zip: _____

Requester: _____ (Case Worker) Phone #: _____

Case Worker Pager: _____ Case Worker Email: _____

Patient's Doctor: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient's Medical Condition: _____

DIAGNOSIS IN LAYPERSON'S TERMS: _____

THIS PAGE MUST BE COMPLETED BY A QUALIFYING PERSON (Doctor, Nurse Social Worker etc.) & MAILED TO :

**Houston Ground Angels
1525 Lakeville Drive Suite 221 Kingwood, TX 77339**



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Treatment Facility at Destination: _____ Phone: _____

Doctor at Destination: _____ Phone: _____

1st Passenger (other than patient): _____ Weight: _____ DOB: _____

Relationship to patient: _____ Phone: _____

2nd Passenger (only if patient is a child): _____ Weight: _____ DOB: _____

Relationship to patient: _____ Phone: _____

Does the patient meet guidelines? Y / N

Is patient ambulatory? Y / N

Crutches? Y/N

Wheelchair? Y/ N

Will the patient be taking oxygen? Y / N

Weight of Oxygen (lbs) _____

Must be small aluminum canisters

If yes, to Wheelchair, weight (lbs) _____ Dimensions _____

Wheelchair must be collapsible

Weight of all baggage: _____ **NOT TO EXCEED 50 LBS!**

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