



5835 West Sunset Avenue • Springdale, Arkansas 72762
 Phone: 479-361-5847 • FAX: 479-361-9104

VAN UTILIZATION PRIORITIZATION TOOL

Patient Name: _____
Address: _____ _____
Phone #: _____
Patient #: _____
Referred by: _____
Phone #: _____ Ext. _____

Clinic: NH or BC MED or RAD

Notes:

Doctor: _____

Start Date: _____

of Treatments: _____

RAD ONC Only: Notified CT Dept.
 (Pam or Sandra 479-695-4205)

Check here	Category	
	A	Patient has absolutely no other means of transportation
	B	Patient should not be driving. Please document i.e. risk of seizure due to tumor, heavy medications, etc. Explain: _____ _____
	C	Patient has limited resources to obtain transportation. Would include patients who could not easily afford the transportation cost and those who have relatives who would have to miss work in order to transport the patient.
	D	Patient lives a great distance or in a remote area of the service area. Please document distance/location: _____
	E	Patient would like to utilize the service for their convenience.

I understand that:

1. My transportation qualification is Category _____.
2. Transportation may not be available at the time my treatments are scheduled.
3. If transportation is made available, I could be removed from the transportation schedule if a person with a higher priority category is identified.
4. I will be notified if transportation is available.

 Patient Signature

 Date

Instructions to Clinical Personnel:

Please forward completed form to Bill Wills at HOPE CANCER RESOURCES.
 Cell: 479-263-3764; Office: 479-361-5847; Fax: 479-361-9104; bill.wills@hopecancerresources.org

The HOPE CANCER RESOURCES Patient Transportation Program is possible through a partnership with the Wal-Mart Foundation and the American Cancer Society.