

**PATIENT TRANSPORTATION INFORMATION AND REQUEST**

**PLEASE NOTE: YOU MUST BE STAYING IN THE CENTRAL/OLD TOWN SCOTTSDALE AREA TO UTILIZE OUR TRANSPORTATION SERVICE.**

**Our Transportation hours are Monday through Friday: 8:30 AM - 5:30 PM**

Transportation must be arranged in advance and is offered on a first come, first served basis. Please help us give you the best service possible by completing the following form and returning it to our office as soon as possible, no later than two weeks prior to your arrival.

**Patient Information**

Patient Name \_\_\_\_\_ Email \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Consultation \_\_\_\_\_ Date of Surgery \_\_\_\_\_

I need transportation for the following. (Please circle all that apply)

Airport Arrival      Airport Departure      Consult/Office Appointment

Surgery/Hospital      Other: \_\_\_\_\_

**Flight Information** (arriving/departing Phoenix Sky Harbor Airport)

**Arrival**

Date: \_\_\_\_\_ Arrival Time: \_\_\_\_\_

Airline: \_\_\_\_\_ Flight No.: \_\_\_\_\_

Arriving from what city: \_\_\_\_\_ Baggage \_\_\_\_\_

Travel Companion \_\_\_\_\_ Special Needs \_\_\_\_\_

**Departure**

Date: \_\_\_\_\_ Departure Time: \_\_\_\_\_

Airline: \_\_\_\_\_ Flight No.: \_\_\_\_\_

**Hotel and Hospital Information**

Hotel Name & Address: \_\_\_\_\_

Number of Nights: \_\_\_\_\_ before surgery      Number of Nights: \_\_\_\_\_ after surgery

Hospital/Recovery Care Center: \_\_\_\_\_

Number of Nights \_\_\_\_\_