ROLLING HILLS CLINIC

TRANSPORTATION DEPARTMENT

RIDE REQUEST/RESCHEDULE/CANCEL FORM

Today's Date: ______________________ **DOB:** ____________________ ☐ **Initial Request**

Patient Name: ____ ☐ **Reschedule**

Phone: ______________________ **Email:** ____________________ ☐ **Cancellation**

Appt Date/Time: ______________________ **Reschedule Date/Time:** ______________________

Location ☐ **Red Bluff** ☐ **Corning** ☐ **Medical** ☐ **Dental** ☐ **PT** ☐ **NAMH**

☐ **Other (referral):** ____

Person Making Request: ____

Provider to be seen: ____

Email request to: **OR Call Transportation Department: 530-690-2792**