



COURT SERVICES, INC
888-202-5036, Ext 2

PRISONER TRANSPORT ORDER FORM
FAX ORDERS: 909-494-4413

CUSTOMER INFORMATION

CUSTOMER NAME _____ ASSIGNOR NAME _____
PHONE NUMBER _____ PURCHASE ORDER # _____

PRISONER INFORMATION

NAME _____ (Last) _____ (First) _____ (Middle)
S.S.# _____ A/K/A _____
D.O.B. _____ SEX _____ RACE _____ BOOKING # _____
HEIGHT _____ WEIGHT _____ HAIR COLOR _____ EYE COLOR _____ INMATE # _____

TYPE OF MOVE

___ BENCH WARRANT ___ COMMITMENT ORDER ___ COURT DATE ___ FORM VI ___ GOVERNOR'S WARRANT
___ IN-STATE ___ INTERSTATE COMPACT ___ WRIT ___ JUDGEMENT ORDER
___ RELEASE DATE ___ PRE-SIGNED WAIVER ___ WAIVER
PICKUP ON DATE _____ COURT DATE _____ DEADLINE (P/U DATE) _____ DEADLINE (D/O DATE) _____
AGENT TO APPEAR IN COURT? YES _____ NO _____
PAPERWORK REQUIRED? YES _____ NO _____ PICKUP WITH ORIGINAL PAPERWORK? YES _____ NO _____

CHARGES & CRIMINAL HISTORY

CURRENT CHARGE(S): _____
CRIMINAL HISTORY: _____
HISTORY OF ASSAULT? YES _____ NO _____ HISTORY OF ACTUAL OR ATTEMPTED ESCAPE? YES _____ NO _____

MEDICAL INFORMATION (CHECK ALL THAT APPLY) (MUST BE COMPLETED BEFORE ORDER IS ACCEPTED)

PRESENT/PAST MEDICAL CONDITIONS THAT MAY EFFECT TRANSPORT --- INDICATE ALL THAT APPLY:
DIABETES ___ HEPATITIS ___ (IF YES, TYPE) _____ HYPERTENSION ___ MENTAL ILLNESS ___ SUICIDAL ___ SEIZURE ___
PREGNANT ___ IF YES, # OF WEEKS _____ ANY COMPLICATIONS? _____
SURGERY WITHIN PAST NINETY DAYS _____ TYPE _____ ANY COMPLICATIONS? _____
IS PRISONER HOUSED IN GENERAL POPULATION ___ INFIRMARY _____ SECLUSION _____ OTHER _____
OPEN WOUNDS _____ DO WOUNDS REQUIRE DRESSING _____

MEDICAL EQUIPMENT & MEDICATION (CHECK ALL THAT APPLY) (MUST BE COMPLETED BEFORE ORDER IS ACCEPTED)

CANE ___ WALKER ___ WHEELCHAIR ___ CASTS/SLINGS (IF YES, WHICH LIMB) _____ COLOSTOMY ___ CATHETER ___
PRESCRIPTION MEDICATIONS / SPECIFY _____

A 10-DAY SUPPLY OF BOTH OVER-THE-COUNTER AND PRESCRIPTION MEDICATIONS MUST BE PROVIDED. IF NECESSARY, A PRESCRIPTION FOR A 10-DAY SUPPLY WILL BE ACCEPTED.

HOLDING AGENCY INFORMATION

AGENCY NAME _____ CONTACT PERSON _____
ADDRESS _____ CITY _____ STATE _____
PHONE No. _____ 24-HOUR PHONE No. _____ FAX No. _____ HOURS _____
SPECIAL INSTRUCTIONS OR RESTRICTIONS _____

DESTINATION AGENCY

AGENCY NAME _____ CONTACT PERSON _____
ADDRESS _____ CITY _____ STATE _____
PHONE No. _____ 24-HOUR PHONE No. _____ FAX No. _____ HOURS _____
SPECIAL INSTRUCTIONS OR RESTRICTIONS _____

UPON PLACING THIS ORDER, YOU AGREE THAT COURT SERVICES, INC WILL NOT BE LIABLE FOR MEDICAL COSTS ASSOCIATED WITH NON-EMERGENCY MEDICAL CARE OR PRE-EXISTING MEDICAL CONDITIONS WHILE IN COURT SERVICES, INC 'S CUSTODY. ALL PRISONER MEDICAL COSTS, INCLUDING, BUT NOT LIMITED TO, THE COSTS OF TRANSPORTATION TO AND FROM ANY MEDICAL FACILITY FOR INCIDENTS NOT DIRECTLY RESULTING FROM COURT SERVICES, INC SHALL BE PAID BY THE CUSTOMER AGENCY. YOU ALSO AGREE THAT COURT SERVICES, INC IS AUTHORIZED TO OBTAIN EMERGENCY AND/OR ROUTINE MEDICAL TREATMENT FOR THE PRISONER WHENEVER DEEMED NECESSARY. IN ADDITION, YOU AGREE THAT COURT SERVICES, INC WILL BILL YOU AN ATTEMPTED PICK UP CHARGE EQUAL TO THE MINIMUM CHARGE WHEN A PRISONER IS NOT PICKED UP DUE TO NO FAULT OF COURT SERVICES, INC. COURT SERVICES, INC WILL REPORT ALL SUCH EXPENDITURES IN DETAIL TO THE CUSTOMER AGENCY.