STANDARD PATIENT TRANSPORT BOOKING FORM

Our Booking Process Explained

Once you submit this Patient Transport Booking Form, our PTS Team will review all the information you have provided.
We will carry out a full risk and resource assessment to determine the safest and most appropriate level of transport support for the patient.

Based on this assessment, we will provide you with a quotation outlining the recommended level of cover. These recommendations are informed by industry best practice, clinical safety standards, and our team's extensive experience in patient transport and pre-hospital care.

You will then have the option to accept the quotation, decline it, or contact us to discuss any adjustments. As a professional and responsible medical transport service, patient safety is always our highest priority. A booking cannot be confirmed until both parties agree on a safe and suitable level of cover for the journey.

To ensure an accurate quotation, please make sure all details in this form are correct. If you have any questions or require assistance while completing the form, please contact us on 0141 212 5770 or email: hello@gmgltd.co.uk.

REQUESTER'S DETAILS (Please note this information is for the person arranging the transport)			
Booker's Full Name:			
Requester's - Full Details Address Town Region			
Postcode		Contact Number:	
Requesters Email Address :			
Where did you hear about Glasgow Medical Group Ltd ?	◯ Internet Search ◯ Word Of Mouth ◯ Other ◯ Ambulance Contract ◯ Facebook ◯ Instagram ◯ Twitter (X) ◯ Linked In		

TRANSPORT DETAILS				
Dates & Times	Pick Up Date:		Drop Off Date:	
	Pick Up Time:		Drop Off Time:	
Pick up Access : Drop Off Access :	◯ Adequate Parking ◯ Ramp Access ◯ Clear route ◯ Ground Floor ◯ Door Wide Enough ◯ Adequate Parking ◯ Ramp Access ◯ Clear route ◯ Ground Floor ◯ Door Wide Enough			
Full Pick Up Address inc Postcode:				
Full Drop Off Address inc Postcode:				

PATIENT'S DETAILS			
Patient's Full Name:		Date Of Birth:	
Mobile Number:		Landline:	
Email Address:			
Any Medical Conditions / History			

INVOICE DETAILS		
Invoice Full Name		
Invoice Address Inc Postcode		
Billing Email		
Telephone:		

INVOICING INFORMATION		
Invoice To:		*These are the details we will use when we invoice you if you accept our quotation.* *If you require us to invoice a company, please include their company registration number.* *Payment terms are clearly displayed on our invoice, late payment may risk cancellation of your cover.* *Further information is available in our booking terms and conditions supplied with your quote.*
Invoice Address:		
Your Order / PO Number:		
Contact Name Email Address:		
Telephone:		
Company Number:		
Authorised to book this request:		

ANY RELEVANT INFORMATION YOU THINK WE SHOULD KNOW

Please expand on the patient's medical condition / history / transportation reason:

Thank you for completing this form, please return it to **hello@gmgltd.co.uk** –
You will receive an email acknowledging we've received it, please allow us a few days to respond with a quote.