# Rainbow Treatment Center
# Dispatch/Trip Report Form

DATE:__________________
NAME OF DISPATCHER:______________________

DRIVER NAME:____________________
VEHICLE TYPE:____________________
LICENSE PLATE #:__________________

| FOR DISPATCH ONLY &/OR CLINICAL | | | | | | | | For Driver's | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Call Time | Name & Phone Number | WELL CHK | AX | TX | Physical Address & Community | Reason For Visit: *(Name of Service & Facilitator)* | BLDG: *(A, B, C, etc)* | Type of Pass: *Dispatch, Sign-In, Individual* | NOTE: |
| 1 | | | | | | | | | | |
| 2 | | | | | | | | | | |
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| 10 | | | | | | | | | | |

**FOR BILLING DEPARTMENT ONLY:**
**Date Rec'd/Inits:__________/______**
**Audit Date/Init__________/______**
**Date Approved For Billing/Inits:__________/______**