DEMO SERVICE - SPECIALTY CARE TRANSPORT

Physician Certification Statement For Ambulance Transportation

(To be completed by hospital personnel/physician and original copy given to transport paramedic)

Run #	

Section 1 - Patient Information

First Name: ____________ Last Name: ____________

SS#: ____________ DOB: ____________

Transport from: ____________ Transport to: ____________

Physician's Printed Name

Sending: ____________ Receiving: ____________

Insurance/Payment

- ☐ Medicare
- ☐ Medicaid
- ☐ Private Insurance
- ☐ Other: ____________

Section 2 - Medical Necessity (Please check all of the following that apply)

Dx Code(s) ____________

☐ The Undersigned does hereby certify that the above named patient

- Is unable to get up from bed without assistance
- Is unable to ambulate, and
- Is unable to sit in a chair or wheelchair (for duration of transport)

☐ This Patient's medical condition is such that other means of transportation is contraindicated

Patient History: ____________

This Patient (check all that apply) - * denotes Specialty Care Transport Criteria

Respiratory:

- ☐ Is ventilator dependent*
- ☐ Is intubated or requires mechanical ventilation*
- ☐ Has a chest tube(s) or tracheotomy
- ☐ Requires continuous oxygen and monitoring
- ☐ Requires airway monitoring or suctioning

Physical Findings:

- ☐ Has unstable neurological signs*
- ☐ Has unstable vital signs requiring continuous monitoring*
- ☐ Has multisystem trauma requiring transfer of definitive care*
- ☐ Is high risk OB Patient (HTN, pre-eclampsia, pre-term, etc.)*
- ☐ Has serious burns requiring treatment at a burn center*
- ☐ Is exhibiting signs of decreased level of consciousness
- ☐ Is seizure-prone and requires monitoring by trained personnel

Higher Level of Care:

- ☐ Requires level of care above ALS level*
- ☐ Meets standard of care*
- ☐ Is being transferred to a facility for higher level of care/specialty care not offered at transferring facility

☐ Other (explain) ____________

IV:

- ☐ Requires IV medication via infusion pump*
- ☐ Requires IV sedation or analgesia*
- ☐ Requires thrombolytics within last 24 hours*
- ☐ Requires monitoring/administration of blood*
- ☐ Requires IV maintenance

Cardiac:

- ☐ Has an arterial line or PA catheter*
- ☐ Has a central line or PIC line*
- ☐ Requires cardiac catherterization
- ☐ Requires continuous cardiac monitoring

Other:

- ☐ Requires restraints
- ☐ Requires isolation precautions (VRE, MRSA, etc.)
- ☐ Has decubitus ulcers and requires wound precautions
- ☐ Weight limit exceeds W/C transport safety limits
- ☐ CVA with paralysis
- ☐ Patient safety
- ☐ Reactive confusion
- ☐ Debilitating weakness due to old age
- ☐ Renal failure
- ☐ Amputation
- ☐ Cannot ambulate
- ☐ Dementia
- ☐ Alzheimer's

Section 3 - Authorized Signature

____________ Signature of Ordering Physician/PA/CNP/Discharge Planner

____________ Date Signed

Ambulance providers are required to obtain a Certificate of Medical Necessity signed by the Patient's physician for the provision of non-emergency transportation. This form is designed to determine if Medical Necessity has been met. Please complete all sections and have the physician sign the form prior to ambulance transportation.