



608-257-9591 • Toll Free 877-257-9591

PHYSICIAN CERTIFICATION STATEMENT FOR AMBULANCE TRANSPORT

COMPLETELY DOCUMENT ALL THAT APPLY AND BE SPECIFIC

Client Name: \_\_\_\_\_ Date of Transport \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_

In my professional opinion, this patient requires transport by ambulance and should not be transported by other means for the reasons listed below:

IMMOBILIZED due to recent fracture or possible fracture: HIP LEG NECK OTHER:

CONTRACTED and CANNOT sit up in a wheelchair: Upper Extremities Lower Extremities Fetal

Suffers from PARALYSIS: Para Quad Hemi

NOT WHEELCHAIR ABLE (Risk of falling off wheelchair or stretcher while in motion.) Reason(s): Poor Trunk Control Postural Instability Spastic/Jerking movement Fetal position Other:

Is BED-CONFINED i.e.: Patient unable to get up from bed without assistance and unable to ambulate and unable to sit in chair or wheelchair. (MUST meet all three criteria in order to meet definition of bed confined)

Please Explain: \_\_\_\_\_

Requires TRAINED MONITORING by EMT/Paramedic for: Airway control/positioning or suctioning Continuous IV therapy Ventilator dependent/advanced airway monitoring Cardiac monitoring Is medicated and requires monitoring Danger to self or others Acute Condition: Explain:

Requires RESTRAINTS Physical - Type: Chemical - Type: Reason: to maintain upright position to prevent from falling prevent from injury to self or others flight risk

MORBID OBESITY Patient Weight: Additional personnel required? Yes No How Many:

AMPUTATIONS and CANNOT sit up in wheelchair: Right Left Bilateral Above knee Below knee

SEVERE PAIN Pain Scale (1-10): (Pain must be aggravated by transfers or moving vehicle such that trained expertise of EMT required.) Detailed Explanation:

Has DECUBITUS ULCERS: Size: Stage: Location: Buttocks Coccyx Hip Other:

Requires OXYGEN enroute. Does patient have his or her own portable oxygen? Yes No Is patient able to administer his or her own oxygen? Yes No If No, WHY:

Requires ISOLATION PRECAUTIONS Why: \_\_\_\_\_

Patient has ALTERED MENTAL STATUS Is this condition: New Onset Normal Status Status Change Does the patient exhibit: Hostile Agitated Violent Non-Compliant

Patient exhibits a DECREASED LEVEL OF CONSCIOUSNESS Unconscious Semi-conscious, stuporous Syncope Seizure prone Unresponsive Intermittent consciousness Incoherent Hallucinating Lethargic Head injury with altered mental status

HOSPITAL TO HOSPITAL TRANSPORTS REASON FOR TRANSFER - CHOOSE ONE

Services are not available at originating facility. What services: \_\_\_\_\_

Insurance Request Physician Request/Convenience Patient/Family Request

Level of Service requested by physician: BLS ALS Critical Care/SCT

I certify that the above information is true and correct based on my evaluation of this patient, to the best of my knowledge and professional training. I understand that this information will be used by the Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services.

Signature of Healthcare Professional: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Title: M.D./D.O. Nurse Practitioner RN PA Discharge Planner Clinical Nurse Specialist

CODE STATUS (PLEASE CIRCLE)

(MD SIGNATURE OR V.O. MUST BE INCLUDED ABOVE TO VALIDATE CODE STATUS)

FULL CODE

DO NOT RESUSCITATE