



PHYSICIAN CERTIFICATION STATEMENT FOR AMBULANCE TRANSPORT

COMPLETELY DOCUMENT ALL THAT APPLY AND BE SPECIFIC

"IF IT DOESN'T SAY BELL ON THE SIDE, YOU'VE JUST BEEN TAKEN FOR A RIDE!!!"

Client Name: _____ Date of Transport: _____

From: _____ To: _____

ROUND TRIP transport on the same day, PCS applies to both transports. Bell Run Number (if known): _____

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: (pounds)
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

FACILITY TO FACILITY 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.
RN
Discharge Planner
Nurse Practitioner
PA
Clinical Nurse Specialist