LONG HORN
Ambulance Services

AMBULANCE TRANSFER FORM (PCS)

PHYSICIAN CERTIFICATION OF MEDICAL NECESSITY STATEMENT

TRANSPORT DATE		Place Patient Sticker Here
TRANSPORT FROM:		
TRANSPORT TO:		
PATIENT NAME:		
DATE OF BIRTH:		
ATTENDING PHYSICIAN:		

CHECK ALL THAT APPLY

☐ **Bed Confined (Must meet all three criteria's):**
1) Unable to Ambulate
2) Unable to get out of bed without assistance
3)Unable to sit in a wheelchair

☐ **Exhibiting sings of decreased level of consciousness**
☐ **Unconscious or in shock**
☐ **Isolation Precautions**

☐ **Patient is ventilator dependent** **Requires (circle all that apply)** Airway Monitoring Cardiac Monitoring
IV Monitoring/ Maintenance Seizure Prone/ requires trained monitoring Medication requires trained monitoring

☐ **Requires oxygen during transport because of :** _____

☐ **Could only be moved by stretcher because of:** _____

☐ **Unable to sit due to decubitus ulcer of the:** _____

☐ **Unable to sit or hold self in place, even with seatbelts, due to paralysis or contractures of the** _____

☐ **Requires (circle all that apply):** Psychiatric Hold Restraints Flight Risk

TRANSFER TO ANOTHER FACILITY

☐ **Requires specialty facility or special services not provided at our facility, please explain** _____

_____

_____

☐ **Patient family/convenience request for transfer**

☐ **No appropriate bed at our facility**

In my professional medical opinion, this patient requires transport by ambulance and should not be transported by other means. This Patient's condition is such that transportation by medically trained trained personnel is required. I certify that the above information is true and correct based on y evaluation of this patient, to the best of my knowledge. I understand that this information will be used by the centers for Medicare and Medicaid and/or its agents to support the determination of the medical necessity for ambulance services.

PLEASE CHECK YOUR CREDENTIALS, PRINT AND SIGN YOUR NAME

☐ **Physician** ☐ **Discharge Planner** ☐ **Case Manager** ☐ **RN** ☐ **NP** ☐ **PA** ☐ **LPN** ☐ **CNS**

PRINTED NAME ***SIGNATURE*** ***DATE***

_____ _____ ____/____/____