RAPID RESPONSE EMS
A Team for Life!

Physician Certification Statement for Ambulance

Run # _____

Patient Name:_____ DOB:_____ Medicare #:_____Gender:_____
Transport Date:_____ (Full) Physician Name:_____ NPI:_____
Origin: _____

_____

Destination: (Include how many days per week to this location and what days, if known) _____

_____

Closest Appropriate Facility? Yes ◯ No ◯ If no, why is the transport to more distant facility required?_____

_____

If hospital to hospital transfer, describe services needed at 2nd facility not available at 1st facility: _____
If hospice patient, is this transport related to the patient's terminal illness? Yes ◯ No ◯ Describe:_____

Section II - MEDICAL NECESSITY QUESTIONNAIRE

Describe the MEDICAL DIAGNOSIS (physical and/or mental) of the patient AT THE TIME OF AMBULANCE TRANSPORT that requires the the patient to be transported BY AMBULANCE: _____

_____

_____

CHECK **ALL** THAT APPLY TO YOUR PATIENT

☐ The patient is "bed confined". (To be bed confined, the patient must be unable to get up from bed without assistance, unable to ambulate **AND** unable to sit in a chair. NOTE: Bed confinement alone does not meet medical necessity for stretcher transport.)
Position of patient during transport, if unable to hold self up: _____

☐ Unable to sit or hold self in place, even with seatbelts, due to (Check all that apply) Paralysis ☐ Contracture ☐ Other: _____
Location:_____Anatomical positioning supervised during transport:_____
Location: _____

☐ Special Handling/Positioning
Fracture of the:_____ Anatomical positioning supervised during transport:_____
Decubitis Ulcer Location: _____Stage:_____Anatomical positioning supervised during transport: _____
Location: _____Stage:_____

☐ Exhibiting signs of decreased level of consciousness due to: _____
EMT to monitor for: _____ Intervention: _____

☐ Patient requires monitoring or treatment by EMT during transport for: (check all applicable items below)

☐ Ventilator dependent - (Settings, medications, monitor for:) _____
_____

☐ IV medications required en route: (Medication, dose, administration instructions, monitor for:) _____
_____

☐ ECG monitoring required en route: (Diagnosis, monitor for:)_____
_____

☐ Oxygen Assistance required en route: (Delivery, amount, reason)____
_____

☐ Suctioning/Airway Control required en route

☐ Seizure prone/requires trained monitoring en route

☐ Medication requires trained monitoring en route

☐ Restraints: Check all that apply:
Chemical ☐ Physical ☐
Reason: _____

One-on-One Supervision: Circle all that apply: Elopement Risk/Danger to Self or Others/Dementia or Alzheimer's with Altered Mental Status
Isolation Precautions (Check all that apply):☐ Standard Precautions ☐Contact Precautions ☐Droplet Precautions ☐ Airborn Precautions
Due to: _____
Other (List reason/need for monitoring of EMT during transport: _____
Can only be moved by stretcher due to: _____

*****USE THE BACK OF THIS FORM FOR ANY ADDITIONAL DETAILS OR NOTES NEEDED*****

SECTION III - SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify that the above information is true and correct based on my evaluation of this patient and represent that the patient requires transport by ambulance and that other forms of transport are contraindicated. I understand that this information will be used by the Centers for Medicare & Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and I represent that I have personal knowledge of the patient's condition at the time of transport.

Signature: _____Date Signed: _____

Signature of Physician* or Healthcare Professional

For scheduled repetitive transports, this form is not valid for transports performed more that 60 days after this date

_____

Printed Name and Credentials of Physician (MD or DO for example)

**Form must be signed only by patient's attending Physician, Nurse Practitioner or Physician Assistant for scheduled repetitive transports. For non-repetitive, unscheduled ambulance transports, if unable to obtain the signature of the attending physician, any of the following may sign.*
(Please note: Only a physician my sign a repetitive, scheduled non-emergent ambulance transport per CMS/Medicare guidelines)