VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Ambulance
Physician's Certification Statement
For Medical Transport Services

SECTION I - PATIENT INFORMATION

Patient's Name: _____ Repetitive?: Y/N Transport Date(s): _____
Medicare or Medicaid# _____ Medicare Replacement# _____ Sex: M / F Date of Birth _____
Transport From: _____ To: _____ Time: _____
Closest Appropriate Facility? ☐ YES ☐ NO - If No, why is transport to a more distant facility required?

If hospice pt, is transport related to PT's terminal condition? ☐ YES ☐ NO
Name of patient's physician ordering transport? _____

SECTION II - MEDICAL NECESSITY QUESTIONNAIRE - Please Complete All Three Steps

Ambulance Transportation is medically necessary only if other means of transport are contraindicated.

1. Is the patient bed confined as defined below? ☐ YES ☐ NO
   - » To be "bedconfined: the patient **MUST SATISFY ALL THREE** of the following 1) unable to get up from bed without assistant, **AND** 2) unable to ambulate **AND** 3) unable to sit in any chair or wheelchair.
2. Can the patient safely be transported in a car or van without medical attention or monitoring? ☐ YES ☐ NO
3. Which of the following best describe the patient's condition? Check all that apply. Multiple areas may be used.

Special Positioning - ☐ Orthopedic device ☐ Hip, knee, or Sternal Precautions s/p fracture or joint replacement ☐ Moderate/ Severe Pain (6/10 or higher) ☐ Unable to maintain hip/ knee flexion ☐ DVT Requiring lower extremity elevation ☐ Fractures, please specify (i.e. greater left trochanteric fracture) _____ ☐ Unable to sit in wheelchair due to surgical incision. **Circle all that apply:** Abdominal, Thigh, Sternum, Other Location: _____ ☐ Unable to sit in wheelchair due to decubitus/ pressure ulcers? **Circle one:** Stage 2 Stage 3 Stage 4 Location: _____

Fall Risk - ☐ Extreme Muscle atrophy, weakness ☐ Contractures ☐ Unable to tolerate seated position for time needed ☐ Unable to brace self in event of a sudden stop ☐ Pt is a quadriplegic or paraplegic ☐ Morbid obesity requires additional personnel/equipment to safely handle patient. Weight must be> 600 lbs. Weight _____lbs

Monitoring for Safety/Altered Level of Consciousness/Psychiatric Needs - ☐ Pt is confused/disoriented (Alert x 2 or less) ☐ Pt is Somnolent ☐ Pt is Catatonic ☐ Patient is unconscious, Glasgow Coma Score _____ ☐ Pt in a Persistent Vegetative State ☐ Pt is impulsive ☐ Pt requires restraints ☐ Danger to self/others ☐ Pt is combative ☐ Pt is delirious

Medical Monitoring - ☐ Requires oxygen, unable to self-administer ☐ Seizures or other neurological concerns ☐ IV Maintenance ☐ Cardiac/Hemodynamic Monitoring

Infectious Disease - ☐ Infectious Disease requiring isolation. **Circle all that apply**: MRSA+ C-DIF+ VRE+ OTHER _____
Location of Infection: **Check All that Apply** ☐ Wound ☐ Nares ☐ Urine Active Diarrhea w/ C-Dif+ Yes or No

Narrative: (Please describe the patients' condition in further detail)

SECTION III - AUTHORIZING SIGNATURE

I certify that the above information is true 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 of Medicare and 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 (CIRCLE) MD PA NP RN DISCHARGE PLANNER Date Signed (Must be 60 days prior to transport)

_____ _____
Printed Name Name of Ordering Physician (MD or PA only)
(Order not Valid Unless MD or PA's name is written here)