

PATIENT STICKER HERE

SECTION I – GENERAL INFORMATION

Patient's Name: _____ Medicare #: _____
 Date of Birth: _____ Transport Date: _____
 (PCS is valid for round trips on this date and for all repetitive trips in the 60-day range as noted below.)
 Origin: _____ Destination: _____
 Is the pt's stay covered under Medicare Part A (PPS/DRG?) YES NO
 Closest appropriate facility? YES NO If no, why is transport to more distant facility required? _____

 If hosp-hosp transfer, describe services needed at 2nd facility not available at 1st facility: _____
 If hospice pt, is this transport related to pt's terminal illness? YES NO Describe: _____

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

Ambulance Transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient's condition. **The following questions must be answered by the medical professional signing below for this form to be valid:**

- 1) Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient's condition:

 - 2) Is this patient "bed confined" as defined below? Yes No
 To be "bed confined" the patient must satisfy all three of the following conditions: (1) *unable* to get up from bed without Assistance; AND (2) *unable* to ambulate; AND (3) *unable* to sit in a chair or wheelchair
 - 3) Can this patient safely be transported by car or wheelchair van (i.e., seated during transport, without a medical attendant or monitoring?)
 Yes No
 - 4) **In addition** to completing questions 1-3 above, please check any of the following conditions that apply*:
 *Note: supporting documentation for any boxes checked must be maintained in the patient's medical records
- Contractures Non-healed fractures Patient is confused Patient is comatose Moderate/severe pain on movement
 Danger to self/other IV meds/fluids required Patient is combative Need or possible need for restraints
 DVT requires elevation of a lower extremity Medical attendant required Requires oxygen – unable to self administer
 Special handling/isolation/infection control precautions required Unable to tolerate seated position for time needed to transport
 Hemodynamic monitoring required enroute Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds
 Cardiac monitoring required enroute Morbid obesity requires additional personnel/equipment to safely handle patient
 Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport
 Other (specify) _____

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 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.

If this box is checked, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, **the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows:**

Signature of Physician* or Healthcare Professional _____ Date Signed _____
 (For scheduled repetitive transport, this form is not valid for transports performed more than 60 days after this date).

Printed Name and Credentials of Physician or Healthcare Professional (MD, DO, RN, etc.)

*Form must be signed only by patient's attending physician 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 check appropriate box below):

- Physician Assistant Clinical Nurse Specialist Registered Nurse
 Nurse Practitioner Discharge Planner

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INTERFACILITY TRANSFER ORDERS

Accepting Physician: _____

Resuscitation States: Full Code / DNR / DNI (Supply signed form if available.)

Most Recent VS: BP: _____ / _____ HR: _____ RR: _____ Temp: _____ O2 Sat: _____

GENERAL ORDERS

VS: q 5 10 15 30 60 minutes

Oxygen: _____ lpm via NC / NRB CPAP: _____ cmH2O

Cardiac Monitoring: YES NO

IV Fluid: Saline or Ringers @ _____ ml/hr

MEDICATIONS/INFUSIONS/VENTILATOR

Med/Infusion 1: _____

Med/Infusion 2: _____

Med/Infusion 3: _____

Med/Infusion 4: _____

Ventilator Settings: Rate: _____ Vt: _____ FiO2: _____ Ti: _____ I/E: _____

PS: _____ PEEP: _____

STANDING ORDERS

ACLS Standing Orders: YES / NO

PALS Standing Orders: YES / NO

Specific Orders:

Physician Signature: _____ Date: _____

Physician name PRINTED: _____ MD / DO / NP / PA