New Hanover Regional Medical Center

Name: _____ (Last Name) _____ (First Name) _____ (Middle Initial)

DOB: _____ MR#: _____

Acct#: _____

Physician Certification Statement for Medical Transport

Complete for non-emergency scheduled and non-emergency unscheduled ambulance transport(s)

SECTION I - GENERAL INFORMATION

Patient's Name: _____ Return to prior arrangement: _____ New Placement: _____

Initial Transport Date: _____ Repetitive Transport Expiration Date (Max 60 Days From Date Signed): _____

Origin: _____ Destination: _____

SECTION II - MEDICAL NECESSITY QUESTIONNAIRE

Non-emergency transportation by ambulance is appropriate if either: the beneficiary is bed confined, and it is documented that the beneficiary's condition is such that other methods of transport are contraindicated; **OR**, if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. (Bed confinement is not the sole criterion.)

To be "bed confined" the patient must be: (1) *unable* to get up from bed without assistance; AND (2) *unable* to ambulate; AND (3) *unable* to sit in a chair or wheelchair (Note: All three of the above conditions must be met in order for the patient to qualify as bed confined)

1) Is this patient "bed confined" as defined above? ☐ Yes ☐ No

2) Describe the Medical CONDITION of this patient AT THE TIME OF AMBULANCE TRANSPORTATION that requires the patient to be transported on a stretcher in an ambulance and why transport by other means is contraindicated by the patient's condition:

_____

3) Can this patient safely be transported in a wheelchair van (i.e., seated for the duration of the transport, and without a medical attendant?) ☐ 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*

- ☐ Advanced airway maintenance required
- ☐ Confused, combative, lethargic, or comatose
- ☐ Danger to self/others or flight risk
- ☐ DVT requires elevation of a lower extremity
- ☐ IV meds/fluids required
- ☐ Moderate/severe pain on movement
- ☐ Morbid obesity requires additional personnel/equipment to safely handle patient
- ☐ Third party assistance required to apply, administer or regulate or adjust oxygen en route (RARE)
- ☐ Other: _____
- ☐ Cardiac/hemodynamic monitoring required
- ☐ Contractures
- ☐ Decubitus ulcers on buttocks, Grade II or greater
- ☐ Isolation/special handling required
- ☐ Maximum assistance required for transfers (2 or more)
- ☐ Non-healed fractures (pelvis, spine, hip)
- ☐ Orthopedic device requiring special handling during transport (backboard, halo, use of pins in traction, etc.)
- ☐ Unable to maintain erect sitting position in a chair for time needed for transport

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 due to the reasons documented on this form. 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 that I have personal knowledge of the patient's condition at the time of transport.

MD*/Healthcare Professional Signature _____ ☐ MD ☐ PA ☐ NP ☐ RN** ☐ CNS** *(check appropriate title)*

Printed name _____ Date _____ Time _____

**Form must be signed only by patient's attending physician for scheduled, repetitive transports.*

***RN or CNS signature must be accompanied by a physician order specifying ambulance transport.*

FAX completed form to 815-5005. Call 815-5155 to verify receipt of FAX.

A completed, signed PCS must be available to Regional Communications (Dispatch) before an ambulance is dispatched.

THIS FORM PART OF PERMANENT MEDICAL RECORD