Dear Columbus Regional Medical Center,

Thank you for utilizing AirLink/VitaLink for your transport needs. If you have additional needs or changes in patient condition to report please contact Regional Communications at 1-800-282-LINK (5465). Please understand that with STEMI patients it is our goal to have a bedside time of 10 minutes or less. We greatly appreciate anything you can do to help us achieve our goal. Click the button below to print the required forms for the type of patient and transport that you have selected and again thank you for utilizing AirLink/ VitaLink.
To be completed by Referral Hospital:

<table>
<thead>
<tr>
<th>Referral Hospital</th>
<th>Columbus Regional Medical Center</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

**Symptom Onset**

**Pertinent Medical History:**
- Previous Stent
- CABG
- Other

**Allergies**

**Patient Weight**

**Is the patient taking any of the following:**
- Warfarin (Coumadin)
- Prasugrel (Effient)
- Dabigatran (Pradaxa)
- Ticagrelor (Brilanta)
- Rivaroxaban (Xarelto)
- Clopidogrel (Plavix)
- Apixaban (Eliquis)

**Medications Administered:**
- Tenecteplase __________ mg
- ASA 325mg PO
- Heparin Bolus 60 IU/Kg __________ IU Administered (max dose of 4,000 IU)
- Clopidogrel 300 mg PO __________ mg Administered (If age> 75, administer 75 mg)
- NTG PRN SL or Paste

- Avoid IV NTG or IV Heparin

**Additional Medications Administered**

**Vital Signs:**
- BP _________   HR _________   RR _________   SaO2 ________

**Prepare patient for rapid transfer:**
- Remove clothing, place patient in gown
- Prep patient and family for rapid handoff to transfer staff
- Have paperwork ready for transfer:
  1. Copy of diagnostic EKG
  2. EMTALA & PCS (AirLink)
  3. STEMI Handoff Sheet
- Fax any additional paperwork to Regional Communications: 910-815-5005

**Referral Hospital Signature:** ________________________________

To be completed by Interfacility Transfer Agency:

| Transfer Agency | ________________________________ | Additional Medications Administered | ________________________________ |

| Additional Interventions Performed | ________________________________ |
| Additional Vital Information | ________________________________ |

**Vital Signs:**
- BP _________   HR _________   RR _________   SaO2 ________

**Referral Agency Signature** ________________________________
**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 TRANSPORT 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.

---

**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 TRANSPORT 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.
Please Include
12-Lead Here
Please Include Patient Chart Here
Please Include
PCS/ EMTALA
Here