Dear Dosher Memorial Hospital,

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). Click the button below to print the required forms necessary for the transport of the patient population you have selected. Thank you again for allowing AirLink•VitaLink to serve your facility’s transport needs.

In preparation for transport the following suggestions are provided to aid in efficient patient transfer at bedside and rapid transport to definitive care. Please understand that with Trauma patients it is our goal to have a **bedside time of 10 minutes or less**. We greatly appreciate your assistance in helping us achieve this goal.

- **Patient and family (Pre-arrival)**
  - Inform the family and patient they are being transferred and the mode of transport that will occur, air vs. ground.
  - Provide the family with an opportunity to visit with the patient. Inform all parties that time is critical. The bedside transfer is a rapid and well choreographed process aimed to deliver the patient to definitive care as efficiently as possible. Please have all family members directed away from the room or bedside once the transport crew arrives.
  - Release patient belongings to the family when possible.
  - Provide driving directions to the family if needed. These are available on the transport website and via the Easy Button.

- **Transport crew (Arrival)**
  - Place completed transfer documents at the head of the patient’s bed including radiology disks or films.
  - Provide bedside report or update to the transport crew.
  - Raise the bed and assist the transport crew with transferring the patient to the stretcher.

Radiology results that become available after the transport crew departs may be securely faxed to 910.815.5649. Help us save time and minimize unnecessary rescans.
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 ☐ Cardiac/hemodynamic monitoring required
☐ Confused, combative, lethargic, or comatose ☐ Contractures
☐ Danger to self/others or flight risk ☐ Decubitus ulcers on buttocks, Grade II or greater
☐ DVT requires elevation of a lower extremity ☐ Isolation/special handling required
☐ IV meds/fluids required ☐ Maximum assistance required for transfers (2 or more)
☐ Moderate/severe pain on movement ☐ Non-healed fractures (pelvis, spine, hip)
☐ Morbid obesity requires additional personnel/equipment to safely handle patient ☐ Orthopedic device requiring special handling during transport (backboard, halo, use of pins in traction, etc.)
☐ Third party assistance required to apply, administer or regulate or adjust oxygen en route (RARE) ☐ Unable to maintain erect sitting position in a chair for time needed for transport
☐ Other: ________________________________________________

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 If Available
Please Include Patient Chart Here