



PO Box 65 Medford, Oklahoma 73759 Phone: (877) 395-0911 Fax: (580) 395-3912

Physician Certification Statement for Ambulance Transport

Please address every line and provide to ambulance crew

Date of Service: \_\_\_\_\_

PATIENT INFORMATION

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Potential Diagnosis: \_\_\_\_\_

REQUESTING FACILITY INFORMATION

Requesting facility: \_\_\_\_\_

Origin Department: [ ] ER [ ] ICU [ ] Floor [ ] Skilled unit [ ] Other: \_\_\_\_\_ Room #: \_\_\_\_\_

Transfer type: [ ] Inter-Facility transfer [ ] Initial trip [ ] Return trip [ ] Other: \_\_\_\_\_

What specialized care is requesting facility not able to provide? Check all that apply.

- [ ] Cardiologist [ ] Cath Lab [ ] Pulmonologist [ ] Neurologist [ ] Gastroenterologist [ ] Orthopedic [ ] ENT
[ ] Trauma services [ ] Surgical services [ ] Pediatric / Neonate specialty [ ] Burn specialty [ ] Wound care [ ] Ob/Gyn
[ ] Rehabilitation unit [ ] Palliative care / Skilled unit [ ] Critical Care or ICU not available at requesting facility.
[ ] Other: \_\_\_\_\_

DESTINATION FACILITY INFORMATION

Destination Facility: \_\_\_\_\_

Facility type: [ ] ER [ ] ICU [ ] Floor [ ] Skilled unit [ ] Other: \_\_\_\_\_ Room #: \_\_\_\_\_

Accepting Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

TRANSFER CRITERIA

- [ ] Patient condition is too unstable and requires ambulance transport to prevent worsening of condition.
[ ] Patient requires a higher or different level of care than the requesting facility can provide.
Does the patient require oxygen? [ ] YES [ ] NO Could the patient self-administer oxygen? [ ] YES [ ] NO
Does the patient routinely require oxygen? [ ] YES [ ] NO If "yes" for what condition? \_\_\_\_\_
Can the patient sit up in a chair? [ ] YES [ ] NO If "yes" how long can patient tolerate sitting? \_\_\_\_\_
If the patient is permanently bed confined, what limitations prevent the patient from getting out of bed?
\_\_\_\_\_
What illness / injury caused the above noted limitations? \_\_\_\_\_
What condition, affected by travel in such a way that without ambulance transfer would bring harm to the patient?
\_\_\_\_\_
What harm might be expected? \_\_\_\_\_

SPECIALTY CARE REQUIRED DURING TRANSPORT Check all that apply.

- [ ] Advanced airway / ventilation management [ ] Ventilator use [ ] Thrombolytic infusion [ ] ECG monitoring [ ] Pain control
[ ] ETCO2 monitoring [ ] Blood product infusion [ ] Vasopressor / IV Fluid support [ ] IV Antibiotic infusion
[ ] Other IV Medications / Titrated Drips: \_\_\_\_\_

Physician, PA, NP, CNS, RN, or Discharge Planner

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_