Transport #_____

Physician Certification Statement

Patient Name: _____ **Date:** _____

Diagnosis: _____

Air Medical Transport Required (Check all that apply)

☐ Patient's condition is **TIME CRITICAL**, requiring rapid arrival to minimize morbidity/mortality. Ground Transport would be hazardous to this patient

☐ Patient's condition required critical care life support & monitoring by an ALS crew.
NOTE: Ground transport is not an option for this patient.

☐ Other:_____

Bypass of Closest Facility Required

I have ordered this patient be transported to a facility that can provide specialist services &/or equipment not available at this facility to manage the complexity of this patient's condition. I acknowledge there may be a geographically closer facility with similar or limited services and am ordering a bypass for the following reason(s):

☐ No beds/accepting physician/specialist available at closer facility.

☐ Specialist/services/equipment unavailable on date of service.

☐ Other (please specify):_____

Name of closer facility(ies) contacted: _____

Reason(s) refused:_____

Inter-facility Transfer Required

The referring facility does not have the following services: (Check all that apply)

☐ Cardiac ☐ Pediatric ☐ Trauma/Burn ☐ Nephrology ☐ Neurology

☐ Pulmonary ☐ Transplant Services ☐ Other specialized services:_____

Non-Emergent Ambulance Transport Required

This patient required **NON-EMERGENT** ambulance transport due to:

☐ Transport by any other means than ambulance is contra-indicated as the patient is unable to walk, stand or sit up for extended periods of time due to:_____

_____ _____

Signature of ordering Physician/PA/ARNP/RN **Date signed**

_____

Printed name of ordering Physician/PA/ARNP/RN

V.4.2018