UNIT NW____________

TRIP # ______________

DATE _____/_____/______

Patient Sticker Here

(425) 328 - 7651

Physician Certification Statement

(ALL FIELDS ARE REQUIRED)

SECTION I

PATIENT'S LAST NAME: ________________________ PATIENT'S FIRST NAME:________________________

PATIENT'S DATE OF BIRTH:______________________

CLAIM DATE(S) SPAN BEING AUTHORIZED FOR TRANSPORTATION:_______________TO________________

DIAGNOSES:____

SENDING FACILITY:____

DESTINATION:____

***** ALL SECTIONS MUST BE FILLED OUT *****

Section II - Qualifying documentation supporting presumptive reasons that non-emergency ground transport by any other means than ambulance is contraindicated. **Supporting documentation for any boxes checked must be maintained in the patient's medical records.**

***** CHECK ALL THAT APPLY: *****

BLS ***Basic Life Support Requirements***

- ☐ Bed Confined - all three must be met. Unable to ambulate, Unable to get out of bed without assistance, Unable to safely sit up in a wheelchair
- ☐ Unable to maintain erect sitting position in a chair for the time needed to transport due to moderate muscular weakness and de-conditioning
- ☐ Third party assistance/attendant required to apply, administer, regulate and/or adjust oxygen en route
- ☐ Unable to sit in chair or wheelchair due to GRADE II or greater decubitus ulcer on buttocks
- ☐ Basic vital signs (blood pressure, pulse, respirations, and SPO2 monitoring during transport)
- ☐ Special Handling en route - isolation
- ☐ Contractures - ☐ upper ☐ lower ☐ right ☐ left
- ☐ Non-healed fractures - ☐ upper ☐ lower ☐ right ☐ left - Location_________________________
- ☐ Moderate to severe pain on movement
- ☐ DVT requires elevation of lower extremity
- ☐ Morbid Obesity requires additional personnel/equipment to handle
- ☐ Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling in transit
- ☐ Severe muscular weakness and de-conditioned state precludes and significant physical activity
- ☐ Restraints (physical or chemical) anticipated or used during transport
- ☐ Danger to self or others (monitoring and/or flight risk)
- ☐ Risk of falling off wheelchair or stretcher while in motion (not related to obesity)
- ☐ Confused, combative, lethargic, comatose
- ☐ I.V. fluids NS or LR at set infusion rate without I.V. pump
- ☐ Higher level of care
- ☐ No inpatient beds at sending facility

ALS ***Advanced Life Support Requirements***

(BLS requirements may also be checked in addition to ALS requirements if needed)

- ☐ Cardiac monitoring required during transport (4 lead, 12 lead, externally paced, pacer pads, pacemaker)
- ☐ Hemodynamic monitoring ☐ Arterial line ☐ CVP ☐ Balloon pump ☐ ECMO
- ☐ Intubated ☐ Ventilator ☐ BIPAP ☐ CPAP ☐ Tracheostomy with deep airway suctioning ☐ High Flow nasal cannula oxygen therapy
- ☐ Chest tube ☐ NG/OG tube
- ☐ Symptomatic hypertension/hypotension ☐ Syncope
- ☐ I.V. medications/fluids (antibiotic infusions, blood products, cardiac medications, dextrose, electrolyte replacement, insulin drip, narcotics)

SECTION III

PROVIDER'S AUTHORIZATION

**I certify that the information contained above represents an accurate assessment of the patient's medical condition on the date of service.*

_______________________	_______________________	_______________________
PROVIDER"S SIGNATURE	PRINTED NAME	DATE

CHECK ONE: ☐Physician ☐PA ☐RN ☐NP ☐CNS ☐DCP ☐LPN ☐SOCIAL WORKER ☐ CASE MANAGER

This authorization must be completed and signed by the attending physician for scheduled repetitive transports. For unscheduled or scheduled non-repetitive transport the authorization may be signed by the attending physician, physician assistant, clinical nurse specialist, nurse practitioner, registered nurse, licensed practical nurse, social worker, case manager or discharge planner (employed by the facility where the beneficiary is being treated) who has personal knowledge of the beneficiary's conditional the time ambulance transport is ordered or furnished.