



Physician's Certification Statement

Patient: _____

Run#: _____

Medicare#: _____

Date of Service: _____

Origin: _____

Destination: _____

Level of Care Required:

- 1. Is the treatment for which the patient is being transferred available at the hospital of origin? Yes _____ No _____
- 2. If treatment is not available, what is the specific service(s) for which the patient is being transported?

Patient's Ambulatory Status:

- 1. Can the patient sit up in a chair? Yes _____ No _____
- 2. If patient can sit in chair, amount of time patient can tolerate sitting: _____
- 3. If patient is confined to bed, what movement limitations prevent the patient from getting out of bed (i.e. location of any paralysis; balance limitations; etc.)?

4. What illness created the movement limitations in #3? _____

Does the patient require O2 for this transport? Yes ___ No ___

1. For what condition is it required? _____

Other Conditions:

1. Other conditions affected by travel in such a way that without ambulance transportation, harm would come to the patient: _____

2. What harm might be expected? _____

Signature _____ Title _____ Date _____

ONLY A PHYSICIAN, RN, DISCHARGE PLANNER, PHYSICIAN ASSISTANT, NURSE PRACTITIONER, OR CLINICAL NURSE SPECIALIST CAN SIGN THIS FORM

Name Printed

TO BE COMPLETED BY AMBULANCE:

MILES TRAVELED ONE WAY:

PLEASE COMPLETE AND SIGN THIS FORM AND GIVE TO TRANSPORTATION PROVIDER