Oklahoma HealthCare Authority

MEDICAL NECESSITY FOR AIR/GROUND TRANSPORT

Many in the air medical industry are calling for standard criteria to determine which patients require air transport. The following referral form is used to evaluate a patient's need for air medical transport.

As the physician requesting air ambulance transport, please fill out this form in its entirety in order to justify why air transportation was required instead of ground transport. (This information will be provided to third party payers.)

(Please Fill All Blanks and Check All That Apply)

PHYSICIAN'S REFERRAL FORM

Patient Name: _____ **Date of Service:** _____

Referring Physician: _____

Diagnosis or potential of the patient: _____

Referring Hospital: _____

□Needs Higher Level of Care

□Weather conditions prohibit ground transport.

□The patient's condition is too critical to allow for longer transport time by ground.

□The patient's condition is too unstable for a ground unit from this institution to transport the patient and requires the special skills and abilities of the transport team.

□Physician Specialist is required for this patient's care and is not available at this institution.
(Please check the appropriate physician consultation or skill required)

□ Cardiologist
□ Vascular Surgeon
□ Neurologist
□ Neurosurgeon
□ Neonatologist
□ Trauma Surgeon
□ Cardiothoracic Surgeon
□ Pediatric Intensive Care Specialist
□ Burn Specialist
□ Other (*please specify)* _____
□ Gastroenterologist
□ Pulmonologist

□Intensive care required for this patient which is not available at this institution.

□Patient may require an emergency procedure that is not available at this institution. The anticipated procedure is:

□CABG
□ Emergent catheterization
□ Emergent CT scan to rule out operable lesion
□ Emergent surgery by a specialist not available at this hospital, i.e. neurosurgery, vascular surgery, pediatric surgery, trauma surgery, reimplantation
□ Balloon angioplasty
□ Emergent dialysis
□ Other (*please specify)* _____

I certify to the best of my professional ability that this patient's condition warrants air/ground ambulance transportation

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____