ASPIRUS®

MedEvac

CERTIFICATE OF MEDICAL NECESSITY FOR AMBULANCE TRANSPORT

SECTION I TRANSPORT INFORMATION

Patient Name: _____ Transport Number: _____

Date of Service (ground repetitive transports may be authorized for 60-day date range): _____

Transported From: _____ Transported To: _____

Sending Physician: _____ Receiving Physician: _____

SECTION II REASONABLENESS FOR TRANSFER OF PATIENT FROM ONE FACILITY TO ANOTHER

☐ **Service not available at originating facility (select all that apply or describe in 'Other'):**

( ) Cardiac Specialty Services ( ) Pulmonary Services ( ) Interventional or Neurosurgical Services
( ) Comprehensive Stroke Care ( ) High-Risk OB ( ) Pediatric Specialty/NICU
( ) Trauma/Burn Services ( ) Surgical Specialty _____ ( ) ICU Care needed
( ) Subspeciality Intervention_____ ( ) Specialized Services_____ ( ) Other_____

SECTION III REASON FOR DESTINATION CHOICE

☐ Reason for destination choice (select all that apply or describe in 'Other':

( ) Specialty Service or Intervention not available at any closer, capable facility
( ) Admission/Bed for necessary intervention not available at any closer facility
( ) Medically necessary transfer per referring provider request
( ) Medically necessary transfer however Patient / Family requested specific destination for preferred specialist
( ) Medically necessary transfer and Health Insurance determines destination / preferred provider
( ) Not Medically necessary transfer but Patient / Family request for transfer
( ) Leave of Absence(LOA) Medically necessary transfer for a procedure/treatment with planned transfer back to originating facility
( ) Other _____

SECTION IV REASON FOR TRANSPORT BY AMBULANCE

☐ **GROUND AMBULANCE Describe the patient's medical condition at time of transport (physical/mental) that would require monitoring or intervention enroute:** _____

Select all that Apply:

( ) IV Medications/Fluids EnRoute ( ) Contractures/Non Healed Fractures ( ) Patient is Confused/Altered Level of Consciousness
( ) Hemodynamic/Tele Monitoring EnRoute ( ) Patient is Sedated/Comatose ( ) Patient Requires Restraints
( ) Requires Oxygen – Unable to Self-Regulate ( ) Patient is a Danger to Self or Others ( ) Patient is Combative
( ) Moderate/Severe Pain ( ) DVT/Contractures Special Positioning ( ) Orthopedic Device/Positioning
( ) Isolation Precautions / Infection Control ( ) Morbid Obesity Requires Special Equipment/Extra Personnel

☐ **AIR AMBULANCE Describe detail about the patient condition that deems Air Ambulance, versus Ground Ambulance, medically necessary:**_____

Select All that Apply:

( ) Time Sensitive Intervention Required
( ) Distance to Intervention, and the time of ground transport travel, is excessive & potentially detrimental to the patient's outcome (greater than 30 to 60 minutes travel time via ground)
( ) No Ground Ambulance Resource Available
( ) Ground Ambulance transport Obstacles or Conditions that would prolong transport time to Urgent Intervention
Weather _____ No Ground Resource _____Road /Traffic Conditions _____Disaster Situation _____

SECTION V REFERRING HEALTHCARE PROVIDER SIGNATURE

Emergency Air or Ground Ambulance Transports, or Non-Emergency/Non-Repetitive Ground Ambulance Transports*, may be signed by these Authorized Healthcare Professionals: Physician, PA, NP, CNS, RN, LPN, Social Worker, or Case Manager*
Non-Emergency/Repetitive Ground Ambulance Transports *require the Attending Physician Signature*

REFERRING HEALTHCARE PROVIDER SIGNATURE_____ **DATE**_____

PRINTED NAME & CREDENTIALS_____