ASPIRUS™ MEDEVAC
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Wausau, WI
800-888-8056

MEDICAL TRANSPORT JUSTIFICATION

Instructions: **This form must be completed and signed by the attending physician prior to any MedEvac transport. Give completed form to MedEvac personnel.**

Patient Label

Date of Transport _____ MedEvac Request # _____

Patient Data

Name _____ Date of Birth _____
First MI Last

Address _____ Billing # _____

City, State, Zip _____ Medicare/Medicaid # _____

Transport Data

Referring Hospital _____ Receiving Hospital _____

City, State _____ City, State _____

Transport Mode ❑ Helicopter ❑ Airplane ❑ Ambulance (MICU)

Is the receiving hospital the closest appropriate facility for this patient? ❑ Yes ❑ No

If no, which hospital is closest? _____

Why is the closest appropriate facility being bypassed? _____

Transport Justification Data

A. The receiving hospital has the following clinical services available at their facility that we are unable to provide. (Check all that apply.)

- ❑ Subspecialty intervention for a multi-system trauma.
- ❑ Subspecialty intervention for an orthopedic injury
- ❑ Specialized pediatric care for a pediatric injury.
- ❑ High-risk Obstetrical services.
- ❑ Hyperbaric treatment for toxic exposure or an emergent condition.
- ❑ Level III nursery care for a neonatal emergency.
- ❑ Diagnostics or intervention for a neurological injury or impairment.
- ❑ Surgical specialist for a gastrointestinal injury or disease.
- ❑ Replantation team for an orthopedic injury.
- ❑ Burn center care for thermal injuries.
- ❑ Invasive diagnostic/intervention for a cardio-thoracic injury or disease.
- ❑ Other (Please state) _____

B. The patient has clinical requirements during transport that exceed those provided by ALS/BLS services. (Check all that apply.)

- ❑ Medical ventilation
- ❑ Advanced arrhythmic therapy
- ❑ Advanced hemodynamic support
- ❑ Invasive arterial, venous or intracranial monitoring
- ❑ Other (Please describe) _____

C. *For Air Transport ONLY* (Check all that apply.) Air Transport is required in order to:

- ❑ Minimize out-of-hospital time. Please give details. _____
- ❑ Provide rapid surgical/procedural intervention. Please give details. _____

Estimated Ground Transport Time _____ ***Estimated Air Transport Time*** _____

Physician Certification Signature

I certify I have completed this report based upon the information available to me at the time of the patient's examination.

Referring Physician's Signature: _____ **Date:** _____ **Time:** _____

Referring Physician Name - Please Print: _____ **Date:** _____ **Time:** _____