NORTH TEXAS REGIONAL EMS

Physician's Certification Statement for Ambulance Transport

Dispatch: (972) 432-6700

Run Number:	Date of Transport:

Pickup Facility	Destination Facility
Pickup Address	Destination Address
Patient Name	Date of Birth / SSN:

Is this transfer **EMERGENT** or **IMMEDIATE**? **Yes** ☐ **No** ☐

☐ Patient requires Skilled Nursing Care	☐ Patient requires Higher Level of Care
☐ Patient requires Rehab Hospital	☐ Patient requires is being discharged home
☐ Patient requires Long Term Acute Care	☐ Patient is still admitted to the facility (Part A)

Closest Appropriate Facility? ☐ Yes ☐ No

If no, why is transfer to other facility required?

Describe services required at receiving facility:

Medical Necessity Questionnaire

Ambulance transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a medical condition such that transport by other means could be potentially harmful and is contraindicated by the patient's condition.

☐ **Yes** ☐ **No** **Is the patient bed confined?**

☐ **Yes** ☐ **No** **Does the patient require ambulance transport?** (The patient cannot be safely transported by any other means without the need for constant monitoring by trained medical personnel)

In addition to answering the above questions, please describe the patient's medical condition at the time of transport:

☐ **Requires Cardiac Monitor (ECG)**	☐ **Altered Mental Status**	☐ **Head Injury**	☐ **Seizure Precautions**
☐ **Requires IV Med/Fluid Monitoring**	☐ **Combative/Self-Endangerment**	☐ **Hemorrhage Risk**	☐ **Sepsis**
☐ **Requires Isolation Precautions**	☐ **Contractures**	☐ **Morbid Obesity**	☐ **Severe Pain**
☐ **Requires Oxygen**	☐ **CVA with Paralysis**	☐ **Orthopedic Device**	☐ **Terminal / End-Stage Disease**
☐ **Requires Airway Management**	☐ **Decubitus Ulcer**	☐ **Post Op Anesthesia Monitoring**	☐ **Unconscious**
☐ **Requires Ventilator**	☐ **Flight Risk**	☐ **Requires Restraints**	☐ **Unhealed Fracture**

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by ambulance. Other forms of transport are contraindicated or could pose a risk to the patient's condition. I understand that this information will be used by the Center for Medicare Services and other insurance payors to determine medical necessity for ambulance services. I represent that I have personal knowledge of the patient's condition at the time of transport. I certify that the institution with which I am affilliated has furnised care, services, or assistance to the patient. If the patient is unable to sign because of mental or physical limitation, my signature may be used on behalf of the patient pursuant to 42 CFR 424.36 (b)(4).

Physician or Nurse Signature		Crew Member Signature	
Physician or Nurse Printed Name		Crew Member Printed Name	
Date	Credentials	Level of Service	Credentials