Summers County
Emergency Medical Services
(304) 466-0312
Physician Statement for Ambulance Transportation

Patient Information

Date(s) of Service

Name:______________________ ___/___/___ to ___/___/___

Patient Transported From:______________________

Patient Transported To: ______________________

Qualifying documentation supporting presumptive reasons that non-emergency ground transport by any other means than AMBULANCE is contraindicated.

Diagnosis:______________________

Supporting documentation for any boxes checked must be maintained in the patients medical records

Check all that apply:

☐ Bed confined • **All three below must be met to qualify for bed confinement •**
Unable to ambulate (walk)
Unable to get out of bed without assistance
Unable to safely sit in a wheelchair
Example: unable to maintain erect sitting position in a chair for time needed for transport due to moderate muscular weakness and conditioning or due to grade II or greater decubitus ulcers on buttocks.

- ☐ Third party medical personnel required to apply, administer, or regulate oxygen during transport
- ☐ **IFT- Specialized Services required/ NOT provided at sending facility**
- ☐ IV medications/ fluids required during transport.
- ☐ Cardiac/ Hemodynamic monitoring required during transport.
- ☐ Special Handling / Positioning due to: **(check all that apply)**
  - ☐ Moderate to severe pain
  - ☐ DVT requires elevation of lower extremity
  - ☐ Extreme edema requires elevation of lower extremity
  - ☐ Decubitus • **stage** ☐ **two** ☐ **three** ☐ **four** **Location**______________________
  - ☐ isolation
  - ☐ Poor skin integrity
  - ☐ Contractures
  - ☐ Non-Healed Fractures
  - ☐ Orthopedic device (backboard, halo, use of pins in traction etc)
- ☐ Morbid obesity requires additional medical personnel or equipment to handle
- ☐ Severe muscular weakness and deconditioned state precludes any significant physical activity.
- ☐ Restraints (physical or chemical) anticipated or used during transport.
- ☐ Danger to self or others -seclusion **(FLIGHT RISK)**
- ☐ Confused, combative, lethargic, or comatose
- ☐ Risk of falling from wheelchair or stretcher while in motion (not related to obesity)
  Example: Poor trunk control or unable to maintain upright seated position while in motion due to time or terrain

Physician/Qualified Personnel Authorization

I certify that the information contained above represents accurate assessment of the patients medical condition on date of service specified

Signature of Physician or Qualified Personnel (see below)	**Printed Name and Title**

This authorization must be completed and signed by the attending Physician for scheduled repetitive transports.
For unscheduled or scheduled non repetitive transports the authorization must be signed by the attending Physician, Physician Assistant ,Clinical Nurse Specialist, Nurse Practitioner, Registered Nurse, or Discharged Planner employed by the facility where the beneficiary is being treated who has personal knowledge of beneficiary's condition at time the ambulance transport is furnished or ordered.