262.335.2911

PHYSICIAN CERTIFICATION STATEMENT FOR AMBULANCE TRANSPORT

DEMOGRAPHICS

Client Name: _____ DOB: _____

Origin: _____ Destination: _____

❑ Services not available: _____

REASON FOR TRANSPORT BY AMBULANCE

Complete All That Apply. Please print clearly.
It is my professional opinion that this patient requires ambulance transport and is unable to transport by other means for the following reasons:

❑ **Fall Risk:** ❑ Poor Trunk Control ❑ Postural Instability ❑ Spastic / Jerking Movement
❑ **Contracted:** ❑ Upper Extremities ❑ Lower Extremities ❑ Fetal
❑ **Amputations:** ❑ Right ❑ Left ❑ Bilateral ❑ Above Knee ❑ Below Knee
❑ **Other:**_____

❑ **Immobilized due to fracture of:** ❑ Hip ❑ Leg ❑ Neck ❑ Back ❑ Other: _____
❑ **Paralysis that results in immobilization:** ❑ Para ❑ Quad ❑ Hemi

❑ **Severe Pain aggravated by movement:** Pain Scale 1-10: _____
Details of pain: _____

❑ **Decubitus Ulcers:** Size _____ Stage: _____
Location: ❑ Buttocks ❑ Coccyx ❑ Hip ❑ Other: _____

❑ **Morbid Obesity requiring additional personnel/equipment.** Weight: _____

❑ **Bed Confined:**
Patient MUST satisfy all three of the following conditions:
1. UNABLE to get up from bed without assistance, AND
2. UNABLE to ambulate, AND
3. UNABLE to sit in a chair or wheelchair

❑ **Isolation Precautions:** _____

❑ **Altered Mental Status and/or Decreased Level of Consciousness:** ❑ New Onset ❑ Normal ❑ Status Change
❑ Unconscious ❑ Syncope ❑ Unresponsive ❑ Incoherent ❑ Lethargic ❑ Semi-Conscious / Stuporous
❑ Seizure Prone ❑ Intermittent Consciousness ❑ Hallucinating ❑ Head injury with altered mental status

❑ **Requires Restraints:** ❑ Physical – Type: _____ ❑ Chemical – Type: _____
Reason: ❑ Maintain upright position ❑ Prevent injury to self or others ❑ Prevent fall ❑ Flight risk
❑ Hostile ❑ Violent ❑ Agitated ❑ Non-Compliant

❑ **Requires Trained Monitoring for:**
❑ Airway control/positioning or suctioning
❑ Requires oxygen – unable to self-administer
❑ Continuous IV therapy
❑ Danger to self or others
❑ Ventilator dependent / advanced airway monitoring
❑ Cardiac monitoring
❑ Sedated/Medicated and requiring monitoring
❑ Other:_____

SIGNATURE

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. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and I represent that I have personal knowledge of the patient's condition at the time of transport.

_____ _____
Physician or Healthcare Professional Dated
❑ MD/DO ❑ PA ❑ RN ❑ Nurse Practitioner ❑ Clinical Nurse Specialist ❑ Discharge Planner

_____
Print Name

LIFESTAR Emergency Medical Services, L.L.C.