Ute Pass Regional Health Service District
Physician Certification Statement for Ambulance Services

Section 1: Patient Information

Affix Patient Information Label Here
Patient Information duplicated on patient label does not need to be filled in on form

Date of Transport: _____/_____/_____

Response Level Code *Circle One*:

Level 1. Emergent and Unstable – *Requiring **immediate** & emergent response*
Level 2. Urgent and Stable – *Requiring **prompt** response by the immediate next available ambulance within 2 hours or sooner.*
Level 3. Non-Emergent and Stable - *Requiring non-emergent response within 4 hours*

Transferring Physician's Name *Please Print*: _____

Patient's Name: _____ **Gender: Male / Female Age:** _____ **DOB:** _____/_____/_____

Calling Facility Name *Circle One*: **Pikes Peak Regional Hospital / Penrose Mtn Urgent Care Center / Other:**_____

Patient Location *If other than Calling Facility:* _____

Destination *Circle One*: **Penrose Main / Memorial Central / Memorial North / St. Francis** / Other:_____

Section 2: Certification of Medical Necessity

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 condition such that transport by means other than ambulance is contraindicated by the patient's condition. To be "bed confined", the patient must be: (1) Unable to get up from bed without assistance; AND (2) unable to ambulate; AND (3) unable to sit in a chair or wheelchair **(Note: ALL THREE OF THE ABOVE CONDITIONS MUST BE MET IN ORDER FOR THE PATIENT TO QUALIFY AS BED CONFINED).**

The following four options must be completed by the medical professional signing below for this to be certification to be valid:

1. Is this patient "bed confined" as defined above? Yes / No
2. Can this patient be safely transported in a wheelchair van or by other alternative means transportation (i.e., seated for the duration of the transport, and without a medical attendant)? Yes / No
3. Other means of transportation is contraindicated because they would endanger the health of the patient. Yes / No
4. Explain/elaborate, in a short statement, on the condition of the patient requiring ambulance transportation and why transport by other means in contraindicated by the patient's condition.

_____

_____

Emergency Department & Urgent Care Facility Criteria

___ Requires continuous oxygen or airway monitoring/support.
___ Requires continuous ECG monitoring.
___ Requires post medication administration monitoring.
___ Other cardiac or other hemodynamic monitoring required enroute.
___ Is comatose/confused/combative or other mentation changes requiring constant trained monitoring.
___ Morbid obesity required additional personnel/equipment.
___ Special handling/isolation required.
___ Other condition (explain) _____

Inpatient and Other Facility Criteria

___ Danger to self/others, flight risk that requires physical or chemical restraints.
___ DVT requiring elevation of a lower extremity.
___ Unable to sit in a wheelchair due to Grade II or greater Decubitus ulcers on buttocks.
___ Orthopedic or other specialized medical device (backboard, halo, use of pins in traction, medication infusion device etc.) requiring special care and handling.

Section 3: Signature of Physician or Other Healthcare Professional

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 due to the reasons documented on this form. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) or other insurance payer to support the determination of medical necessity for ambulance services, and that I have personal knowledge of the patient's condition at the time of transport.

_____ _____ _____/_____/_____
Signature of Physician* or Healthcare Professional **Printed Name and Title** **Date of Signature**

***For non-repetitive, unscheduled ambulance transports** this form may be signed by any person who is directly associated with the patient's care at the time of transport if the attending physician is unavailable to sign.