CURTIS
AMBULANCE SERVICE

MADISON (608) 255-4140
MILWAUKEE (414) 933-7600
TOLL FREE 1-800-236-7828

Emergency Medical Services

PHYSICIAN CERTIFICATION STATEMENT FOR AMBULANCE TRANSPORT

Patient Name:_____ Date:_____

Instructions: A physician, RN, discharge planner, nurse practitioner, PA or clinical nurse specialist employed by the attending physician, the hospital or the facility where the patient is treated may sign the PCS.

IS THIS PATIENT ABLE TO BE TRANSPORTED BY WHEELCHAIR? YES/NO

In my professional opinion, this patient requires transport by ambulance and should not be transported by other means. The patient's condition is such that transportation and observation by medically trained personnel is required. I have checked the appropriate boxes and wrote explanation(s) below to indicate the specific medical conditions and requirements that require the patient to be transported by ambulance. The above named patient:

~DOCUMENT ALL THAT APPLY AND ANSWER COMPLETELY~

☐ Is on continuous oxygen in the facility for an acute or Chronic condition and requires continuous oxygen enroute.
Does this patient have their own portable oxygen?
Is patient able to administer their own oxygen?
If No, WHY:_____

☐ Requires restraints because:_____
☐ Physical-Type: _____
☐ Chemical-Type: _____

☐ **Requires isolation precautions because:** _____

_____

☐ Is immobilized due to recent fracture or possible fracture:
☐ hip; ☐ leg; ☐ neck; ☐ other:_____
Orthopedic device required:_____

☐ Is contracted and CANNOT sit up in a chair:
☐ upper extremities; ☐ lower extremities; ☐ fetal

☐ Has decubitus ulcers: Size _____; Stage _____
Location: ☐ buttocks; ☐ coccyx; _____
hip; ☐ _____ Other; _____

☐ Not wheelchair able (Risk of falling off wheelchair or Stretcher while in motion)
Reason:_____

☐ Suffers from paralysis: ☐ para; ☐ quad: ☐ hemi
Is patient able to sit in a wheelchair for transport? No
If No, why not?_____

☐ **Is Bed Confined? (All must be YES to apply)**
☐ **Is patient unable to get up from bed without assistance?**
AND
☐ **Is patient unable to ambulate?**
AND
☐ **Is patient unable to sit in chair or wheelchair?**
Reason for Yes answer:_____

☐ Danger to Self or Others:
☐ Behavorial or Cognitive Risk:_____
☐ Seclusion (Flight Risk)

☐ Requires Trained Monitoring for:
☐ Requires airway control/positioning or suctioning
☐ Requires continuous IV therapy
☐ Is ventilator dependent/advanced airway monitoring
☐ Requires cardiac monitoring
☐ Is medicated and requires monitoring
Detailed explanation:_____

_____

☐ Morbid Obesity which requires additional personnel or equipment to transfer. Patient weight_____

☐ Severe Pain. Pain must be aggravated by transfers or Moving vehicle such that trained expertise of EMT required.
Pain Scale (1-10):_____
Detailed explanation:_____

_____

WHY IS PATIENT BEING TRANSPORTED? (Required)_____

I certify that the above information is true and correct based on my evaluation of this patient, to the best of my knowledge and professional training. I understand that this information will be used by the Department of Health and Human Services. Health Care Financing Administration (HCFA) to support the determination of medical necessity for ambulance services.

Printed name of physician	Signature	Date

OR

Printed name of RN, discharge planner Nurse Practitioner. PA or Clinical Nurse Specialist	Signature	Date