E.A.S.T. AMBULANCE PHYSICIAN CERTIFICATION STATEMENT - STRETCHER

PATIENTS NAME_____ DATE OF SERVICE _____ To _____
REPETTVE TRANSPORTS ONLY

ORIGIN _____ TRANSPORT TO: _____

DOCUMENTATION OF MEDICAL NEED FOR STRETCHER

BED CONFINEMENT: TO BE "BED CONFINED" THE PATIENT MUST MEET ALL OF THE FOLLOWING CRITERIA:

1. UNABLE TO GET OUT OF BED WITHOUT ASSISTANCE
2. UNABLE TO AMBULATE
3. UNABLE TO SIT IN A WHEELCHAIR

THIS PATIENT IS UNABLE TO BE SAFELY TRANSPORTED IN A WHEELCHAIR OR BY OTHER MEANS AT THE

TIME OF TRANSPORT BECAUSE:

_____

SUPPORTING DOCUMENTATION

CHECK THE FOLLOWING CONDITIONS THAT APPLY TO THIS PATIENT

- ☐ CONTRACTURES
- ☐ DANGER TO SELF/OTHERS
- ☐ NON-HEALED FRACTURES
- ☐ IV MEDS/FLUIDS REQUIRED
- ☐ MODERATE/SEVERE PAIN ON MOVEMENT
- ☐ RESTRAINTS (PHYSICAL/CHEMICAL) ANTICIPATED/USED DURING TRANSPORT
- ☐ PATIENT IS CONFUSED, COMBATIVE, LETHARGIC, OR COMATOSE
- ☐ CARDIAC/HEMODYNAMIC MONITORING REQUIRED ENROUTE
- ☐ DVT REQUIRES ELEVATION OF LOWER EXTREMITY
- ☐ SPECIAL HANDLING/ISOLATION REQUIRED
- ☐ THIRD PARTY ASSISTANCE/ATTENDENT REQUIRED TO APPLY, ADMINISTER OR REGULATE OXYGEN ENROUTE
- ☐ UNABLE TO SIT IN A CHAIR OR WHEELCHAIR DUE TO GRADE 2 OR GREATER DECUBITUS ULCERS ON BUTTOCKS
- ☐ ORTHOPEDIC DEVICE (BACKBOARD, HALO, USE OF PINS IN TRACTION, ETC.) REQUIRING SPECIAL HANDLING DURING TRANSPORT

SIGNATURE OF HEALTHCARE PROFESSIONAL

SCHEDULED REPETITIVE TRANSPORTS- THIS AUTHORIZATION MUST BE SIGNED BY THE **ATTENDING PHYSICIAN.**

SCHEDULED NON-REPETITIVE TRANSPORTS- THIS AUTHORIZATION MAY BE SIGNED BY THE **ATTENDING PHYSICIAN**, **REGISTERED NURSE** OR **LICENSED SOCIAL WORKER** EMPLOYED BY THE FACILITY WHERE THE PATIENT IS BEING TREATED AND HAS PERSONAL KNOWLEDGE OF THE PATIENTS CONDITION AT THE TIME AMBULANCE TRANSPORTATION IS ORDERED OR FURNISHED.

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) AND/OR ANY OTHER INSURER TO SUPPORT THE DETERMINATION OF MEDICAL NECESSITY FOR AMBULANCE SERVICES, AND THAT I HAVE PERSONAL KNOWLEDGE OF THE PATIENTS CONDITION AT THE TIME OF TRANSPORT.

SIGNATURE AND TITLE OF HEALTHCARE PROFESSIONAL.	PRINTED NAME	DATE SIGNED

Eastern Area Specialty Transport Inc. 1000 Industrial Park Drive Leesburg, Ohio 45135

Revised 08/06/2010