

**PHYSICIAN CERTIFICATION
STATEMENT AMBULANCE
TRANSPORTATION**

Patient's Name: _____ DOB: _____
 Date(s) of Ambulance Transport: _____ Thru: _____
 Physician's Name: _____ Office Phone: _____
 Physician's Address: _____

In my professional opinion, the above named patient cannot be safely transported by any means other than an ambulance with medically-trained personnel. (Please check ALL that apply.)

- This patient: has paralysis has amputations (identify site) _____
- is unable to get up from bed without assistance.
 - is unable to ambulate without assistance.
 - is unable to sit in a chair or wheelchair without risk of fall without assistance.
 - requires exit via stair chair stretcher, scoop or backboard.
 - requires 2 or more attendants to transfer.
 - total body lift from bed to stretcher. stretcher to bed.
 - total body lift from chair to stretcher.
 - has major orthopedic device applied (halo traction, spine board).
 - for special handling due to pain (specify) _____
 - for special handling due to decubiti (enter site, stage) _____
 - for special handling due to recent post-op hip fracture (enter site, date) _____
 - for special handling due to obesity (enter weight) _____
 - for special handling due to contractures (enter site) _____
 - requires an EMT attendant during transport:
 - for airway monitoring and possible suctioning.
 - for non self-administered oxygen ____ lpm.
 - for isolation precautions (MRSA/VRE).
 - for monitoring due to a behavioral or cognitive risk (check below):
 - patient is drowsy, medicated with _____,
 - agitated, confused, incoherent, blind, deaf, non English speaking
 - for monitoring due to a high risk for fall.
 - other (explain the checkbox above **or** give other reason): _____

Current Diagnoses and Medical History:

Signature: _____
 (Signature of MD, PA, NP, CNS, RN or Discharge Planner ordering the above services) Date of Signature _____

Print Name and Title: _____