PHYSICIAN/QUALIFIED MEDICAL PERSONNEL STATEMENT
MEDICAL NECESSITY AND REASONABLENESS FOR AIR MEDICAL TRANSPORT

As the medical professional involved in the air ambulance transport provided by _____
(Air ambulance supplier)

Please complete this form in its entirety in order to justify why air transportation was required instead of ground transport. (This information will be provided to third party payers.)

Patient Data

Please Complete Each Section and Check All That Apply

Call # _____ Patient Name _____

Date of Service_____ Date of Birth_____

Diagnosis or Potential Diagnosis of Patient _____

Requesting Source

Requested By (full name and title) _____

Requesting Entity (name and contact) _____

Accepting-Receiving Hospital _____

Requesting Air Transport General Criteria

☐ The Patient's condition is too critical to allow for longer transport time by ground

☐ Patient requires higher level of care ☐ Facility on Divert

☐ Weather / road conditions prohibit ground transport

☐ The patient's condition is too unstable for a ground unit and requires critical care abilities of the air ambulance transport team.

Specify care:

☐ Intubated ☐ ETCO2 Monitoring ☐ TPA Infusion ☐ EKG ☐ IABP ☐ Fetal Monitoring ☐Neonatal Isolette ☐Glidescope Intubation

☐ Other _____ ☐ IV Medications, titrated drips (specify medications) _____

Mechanism of Injury

☐ Patient requires immediate and rapid transport due to the nature and or severity of the illness / injury
(Please check the Mechanism(s) of Injury)

☐ Vehicle rollover / ejection / high speed collision
☐ Vehicle striking pedestrian > 10 mph
☐ Falls from > 15 feet
☐ Motorcycle victim ejected at > 20 mph
☐ Near drowning injuries
☐ Major crush injuries
☐ AMI / Chest pain
☐ Other (specify) _____

☐ Symptomatic hypotension
☐ High-risk obstetrical conditions
☐ Penetrating trauma
☐ Spinal Cord / spinal column injury
☐ Partial or total amputation
☐ 2 or more long bone fx. Pelvic fx,
☐Altered level of consciousness

☐ Patient experiencing neurological impairment (CVA, Stroke, Seizures)
☐ Symptomatic hypertension
☐ Major burns of the body surface area; burns involving the face, hands, feet, perineum; burns with significant respiratory involvement; major electrical or chemical burn
☐ Same vehicle fatality

Specialty Care Required

☐ Specialty Care likely required for this patient's immediate care. **(Please check the appropriate physician consultation or skill likely required)**

☐ Cardiologist
☐ Cardiothoracic Surgeon
☐ Vascular Surgeon
☐ Neurologist
☐ Neurosurgeon
☐ Neuroradiologist

☐ Pulmonologist
☐ Gastroenterologist
☐ Neonatologist
☐ Pediatric Intensive Care Specialist
☐ Burn Specialist
☐ Trauma Surgeon

☐ ICU Not Available at referring
☐ Other (specify)_____
_____
_____
_____

I order/certify that this patient's condition requires Air Ambulance Transportation due to the time or geographical factors. Such certification is to the best of my professional ability. By so certifying, I am NOT assuming any financial responsibility for the transportation services provided by: _____ . The ambulance supplier agrees that it will bill only the patient or any applicable third party payor for any transportation cost.
(Air ambulance supplier)

Signature/Date _____ **Name (print)** _____

☐ EMT ☐ Paramedic ☐ Trained First Responder ☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner ☐ R.N. _____ per VO/TO of Dr. _____

Do you (requesting source) have a financial/employment relationship with the ambulance supplier transporting patient?

Revision Date 1/1/2013 **Please Indicate** ☐ Yes ☐ No