

Facility Name: _____

Transport Date: _____

Patient Name: _____
First M.I. Last

Room # or Dept: _____

Date of Birth: _____
Mo/Day/Year

Destination: _____

Requested Pick-Up Time: _____

This Section Completed by Physician:

DOCUMENTATION OF MEDICAL NECESSITY

- Transport for Emergency Situation (accident, injury or acute illness)
- Bed Confined: The patient is unable to get out of bed without assistance, unable to ambulate and unable to sit in a chair or wheelchair.

Could only be moved by stretcher. Please check box that applies:

- Requires continuous oxygen (other than chronic)
- Requires airway monitoring
- Is ventilator dependent
- Is comatose and requires trained monitoring
- Is on hip precautions and cannot sit safely
- Needs restraints
- Does not meet Medical Necessity Criteria
(This does not need a physician's signature)
- Cannot support themselves safely while seated in wheelchair (explain below)
- Is able to tolerate a wheelchair but is medically unstable due to other conditions indicated below
- Requires medical supervision during transport (explain below)

Explain/elaborate on the conditions of the patient requiring ambulance transportation:

PHYSICIAN'S SIGNATURE

As the patient's physician or authorized representative, I verify that the sending facility has complied with all applicable federal, state and local laws governing the transport of this patient. I further verify that the mode of transportation is appropriate for this patient. I also certify that the above information is correct and that I am authorized by this facility to request medical transportation.

R.N. Signature (must be authorized by physician): _____ Date: _____

Print Physician's Name: _____

Physician's Signature: _____ Date: _____
(Note: Physician's Assistant, Clinical Nurse Specialists, and Nurse Practitioners are also authorized to sign)

PCS COORDINATOR:
Becky Ottman (970) 244-1467

AMBULANCE DISPATCH #:
(970) 242-HELP (4357)

FAX NUMBER:
(970) 244-1471

**THIS IS A REQUIRED
HCFA DOCUMENT**

TRIP #: