FREEDOM EMS
VETERAN OWNED. VETERAN EMPLOYER.

PHYSICIAN CERTIFICATION STATEMENT for NON-EMERGENCY AMBULANCE SERVICES
HOSPITAL DISCHARGES/SKILLED NURSING FACILITY/INTERFACILITY TRANSPORTS

Patient: **DOB:** **Date of Transport:**

Date of Admission: **Diagnosis:** **Physicians Name:**

Patient is being transported **FROM**: ☐ **INPATIENT** ☐ **ED** ☐ **SNF** *(Skilled Nursing Facility)*

TO: ☐ **Skilled Care** ☐ **Nursing Home** ☐ **Custodial Care Facility** ☐ **Residence** ☐ **Outpatient Service** ☐ **Rehabilitation Service**
☐ **Psychiatric Center** ☐ **Long-Term Care** ☐ **Higher Level of Care for Tx of:**

A patient is **BED CONFINED** if he/she is unable to get up from bed without assistance **AND** unable to ambulate, **AND** unable to sit in a chair (including a wheelchair).
Based on the above definition, is the patient **BED CONFINED**?

☐ **YES** Bed confined due to:

☐ **NO** However, patient cannot be transported by any other mode of transportation because:

MARK ALL APPLICABLE CONDITION(S) TO SUPPORT ONE OF THE ABOVE STATEMENTS

☐ **Requires medical monitoring of vital signs during transport** ☐ **Requires medical aid during transport**

☐ **Requires medical care during transport** ☐ **Requires medical treatment during transport**

State reason(s) for any of the above:

☐ **Requires tracheostomy monitoring** ☐ **Requires or possible suctioning**

☐ **Requires assistance to administer oxygen due to:** ***(Please select and/or enter all applicable information below)***

☐ **COPD** ☐ **Respiratory Failure** ☐ **Lung Cancer** ☐ **CHF** ☐ **Other respiratory abnormality:**

☐ **Administered by:** ☐ **NRB Mask** **@** **LPM** ☐ **Ventilator Support**

☐ **Requires isolation due to:** ☐ **AIDS** ☐ **Advanced** ☐ **End Stage** ☐ **VRSA** ☐ **C-Diff** ☐ **Other:**

☐ **Obesity** **Weight:** **Height:** **BMI:**

Pain Scale ***(select only one)*** ◯ **1** ◯ **2** ◯ **3** ◯ **4** ◯ **5** ◯ **6** ◯ **7** ◯ **8** ◯ **9** ◯ **10** **Site:**

☐ **Altered Level of Consciousness:** ***(select only one)*** ☐ **Unconscious/Semi-conscious** ☐ **Coma** ☐ **Vegetative State**

☐ **Altered mental status secondary to:** *(Please select and/or enter all applicable information below)*

☐ **Dementia** ☐ **Alzheimer's Disease** ☐ **Organic Brain Syndrome** ☐ **Advanced** ☐ **End Stage**

☐ **CVA** ***date of CVA:***

☐ **Hallucinations** ☐ **Suicidal Ideations** ☐ **Delirium Tremors** ☐ **Drug or Alcohol Withdrawals**

☐ **Severe Anxiety** ☐ **Exacerbation of Paranoia** ☐ **Combative or Violent Behavior**

☐ **Requires restraints** ***(choose type)*** ☐ **Verbal** ☐ **Chemical** ☐ **Physical**

☐ **Paralysis secondary to CVA** ***date of CVA:*** **Location of Paralysis:**

☐ **Requires special handling or immobilization due to:** *(mark all that apply below)* ☐ **Fall Risk due to:** *(mark all that apply below)*

☐ **Paralysis**	**Site:**	☐ **RT**	☐ **LT**	☐ **Unsteady gait/balance**	☐ **Weakness**
☐ **Amputation**	**Location:**	☐ **RT**	☐ **LT**	☐ **Bilateral**	
☐ **Contractures**	**Location:**	☐ **RT**	☐ **LT**	☐ **Bilateral**	
☐ **Fracture**	**Location:**	☐ **RT**	☐ **LT**	☐ **Bilateral**	
☐ **Dislocation**	**Location:**	☐ **RT**	☐ **LT**	☐ **Bilateral**	

☐ **Other** *(please explain)*

☐ **Decubitus** **Location(s)** **Stage:** ☐ **RT** ☐ **LT** ☐ **Bilateral**

☐ **Cancer** ☐ **METS** **Type:** **Stage:**

☐ **Other:**

HOSPITAL TO HOSPITAL TRANSFERS

CHECK ALL THAT APPLY

☐ **Advanced care or higher level of care:** *(name of procedure or care)*

☐ **Bed availability**

☐ **Specialists not available at origin:** *(type of specialist)*

By signing below I certify that the above information is correct and true based on my evaluation of this patient's current medical condition. Transportation by other means place this patient's general welfare in jeopardy or cause impairment of bodily function. I understand this information will be submitted to the insurance provider to support the determination of medical necessity for ambulance services. I also certify that our institution has furnished care of other services to the above named patient.

Print Name **Signature** **Title** **Date** **Phone**

MARK ONE: ☐ **MD** ☐ **PA** ☐ **RN** ☐ **NP** ☐ **CNS** ☐ **Discharge Planner/Case Manager**

FAX COMPLETED AND SIGNED FORM TO: 815-926-2319
NOTE* THE PRESENCE OF A SIGNED PCS DOES NOT GUARANTEE PAYMENT OR INSURANCE COVERAGE