Metro
Ambulance Service

Non-Emergency Ambulance Service Request: Hospital Version - 14 June 2016

Please complete and fax to Metro Ambulance Service @ 601-482-1316

Date of Transfer: ______________________ **MTM Contacted?** ☐ Yes ☐ No

Patient's Name: ______________________ **MTM Operator Name:** ______________________

Sending Facility/Room #: ______________________ **MTM Trip ID#:**

Receiving Facility: ______________________

Sending Doctor's First & Last Name: ______________________

First & Last Name of Receiving Doctor: ______________________

Person requesting Transfer First & Last Name Printed: ______________________

Pick Up Time: ______________________ **Appointment Time:** ______________________

This patient has:

☐ **Medicare #:** ______________________

☐ **Medicaid #:** ______________________

☐ **Other:** ______________________

☐ **Magnolia, Windsor Medicare United Healthcare, or Chips**

Policy #: ______________________

Patient DOB: ______________________ **Patient SSN:** ______________________

Admitting Diagnosis:

Reason for today's transport?

Medical Devices Required:

☐ **IV Medications Required**

☐ **Oxygen**

☐ **ECG Monitoring**

☐ **Orthopedic Devices Required**

☐ **Tracheostomy**

☐ **Special Handling/Isolation**

Transport Type Requested:

☐ **Stretcher (Must have Medical Necessity Form Faxed with this Request)**

☐ **Wheelchair (Lauderdale County Only, M-F 0700-1700**

Signature of Person Requesting Transfer: ______________________ **Phone** ______________________

If a response has not occurred to your request for service, a confirmation phone call should be made to Metro Ambulance Service @ 601-483-2260.

If your patient is a discharging to a residence, we must have the name and telephone number of a relative prior to dispatching the ambulance.

Printed First/Last Name of Relative: ______________________ **Telephone #:** (____) ______________________

METRO AMBULANCE SERVICE:

PHYSICIAN CERTIFICATION STATEMENT FORAMBULANCE TRANSPORT

SECTION I - GENERAL INFORMATION

Version - August2014

Patient's Name:____________________ Date of Birth:__________ Medicare #: ____________________

Medicaid # : ____________________ Transport Date:____________________

Origin of Transport: ____________________ Destination: ____________________

SECTION II - MEDICAL NECESSITY QUESTIONNAIRE

Non-emergency transportation by ambulance is appropriate if either: the beneficiary is bed confined, and it is documented that the beneficiary's condition is such that other methods of transport are contraindicated; **OR**, if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. (Bed confinement is not the sole criterion.)

To be "bed confined" the patient must be: (1) *unable* to get up from bed without assistance; AND (2) *unable* to ambulate; AND (3) *unable* to sit in a chair or wheelchair (Note: All three of the above conditions must be met in order for the patient to qualify as bed confined)

The following questions must be answered by the medical professional signing below for this form to be valid:

1) Is this patient "bed confined" as defined above? ☐ Yes ☐ No

2) Describe the Medical CONDITION of this patient AT THE TIME OF AMBULANCE TRANSPORTATION that requires the patient to be transported on a stretcher in an ambulance and why transport by other means is contraindicated by the patient's condition:
____
____
____

3) Can this patient safely be transported in a wheelchair van (i.e., seated for the duration of the transport, and without a medical attendant?) ☐ Yes ☐ No

4) ***In addition*** to completing questions 1-3 above, please check any of the following conditions that apply*:
**Note: supporting documentation for any boxes checked must be maintained in the patient's medical records*

☐ Contractures-Fetal ☐ Non-healed fractures ☐ Moderate/severe pain on movement
☐ Danger to self/others ☐ IV meds/fluids required ☐ Special handling/isolation required
☐ Restraints (verbal, physical or chemical) anticipated or used during transport
☐ Patient is confused, combative, lethargic, or comatose
☐ Cardiac/hemodynamic monitoring required enroute
☐ DVT requires elevation of a lower extremity
☐ Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling
☐ Unable to maintain erect sitting position in a chair for time needed to transport
☐ Unable to sit in a chair or wheelchair due to Grade III or greater decubitus ulcers on buttocks, or hips- Circle Location of Decubitus
☐ Morbid obesity requires additional personnel/equipment to safely handle patient- Patient Height/Weight? __________
☐ Other: ____

SECTION III - SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

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) to support the determination of medical necessity for ambulance services, and that I have personal knowledge of the patient's condition at the time of transport.

I understand that this form is the property of Metro Ambulance Service, and will surrender the ***original form- signed and completed-*** at the time the patient is transported.

______________________________ ______________________________
Signature of Physician* or Healthcare Professional Date Printed Name and Title

**Form must be signed only by patient's attending physician for Medicaid, scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, the form may be signed by any of the following if the attending physician is unavailable to sign (please check appropriate box below)*

☐ Physician ☐ Clinical Nurse Specialist ☐ Registered Nurse
☐ Nurse Practitioner ☐ Discharge Planner