Run #________________ (Medstar crew to complete)

Place patient sticker here

Macomb County: (586) 468-0577 **Oakland County:** (248) 294-5864 **Wayne County:** (313) 886-7799
Flint: (810) 272-2005 **Lapeer:** (810) 553-4442 **Lansing:** (517) 512-6168

PHYSICIAN CERTIFICATION STATEMENT PCS

Attending Physician: ___________________________________ Attending Physician NPI # ____________ **TRANSPORT DATE:** ____________

Patient Name: ____ Date of Birth:___/___/____ Medicare/Medicaid ID: ____________________

FROM/ORIGIN: ________________________________ TO/DESTINATION: __________________________ ROUND TRIP? YES___ NO ___

MEDICAL NECESSITY – MUST COMPLETE

Describe patient's condition (not diagnosis) at this time that necessitates utilization of an ambulance: ______________________________

____

Is patient **BED Confined**? ☐ Yes ☐ No **CMS Definition:** is unable to get up from bed without assistance, **and** is unable to ambulate, **and** is unable to sit in a chair or wheelchair.

If the patient does not meet bed-confined criteria, can patient safely be transported by wheelchair van? ☐ Yes ☐ No

Please **CHECK ALL** Medical Conditions that apply

- ☐ Patient is paralyzed ☐ **Hemi** ☐ **Semi** ☐ **Quad**
- ☐ Contractures **Specify** location ______________________
- ☐ Requires care/monitoring during transport
- ☐ Has Stage II or greater decub ulcers
  - ☐ **Coccyx** ☐ **Buttocks** ☐ **Hip** ☐ **Feet**
- ☐ Vent Dependent
- ☐ Medical Attendant required monitor/supervise____________
- ☐ Requires airway monitoring/suctioning
- ☐ Non-healed fractures **Specify** location:___________________
- ☐ Postural instability or unable to hold self in upright position due to_______________________________________
- ☐ Patient has amputations. **Specify:**
  - ___ Above the knee ___ Below the knee ___ Unilateral
- ☐ Requires IV maintenance ☐ Seizure prone
- ☐ Patient given SEDATIVES or NARCOTICS prior to transport
- ☐ Requires Oxygen _____ **LPM** *Unable* to self admin/NO portable unit
- ☐ Morbidly Obese requires additional personnel or equipment
- ☐ Unable to be transported in a seated position due to ____________
- ☐ Patient has postural instability or is unable to hold self in upright position due to __________________.

- ☐ Decreased level of consciousness: ☐ Dementia ☐ Lethargic ☐ Altered Mental Status ☐ Comatose
- ☐ Psychiatric: **Diagnosis**____________________ ☐ Flight Risk ☐ Patient requires restraints other than usual seat belts ☐ Danger to self/others ☐ Combative

*TRANSFER FROM HOSPITAL TO HOSPITAL

☐ Requires ***Specialty*** physician or Services not available at sending facility
(***describe**): ____

NOTE: LACK OF ALTERNATIVE TRANSPORTATION SERVICES DOES NOT CREATE A MEDICAL NECESSITY FOR AMBULANCE SERVICES.

SIGNATURES – 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 and that other forms of transport are contraindicated.

SIGNATURE OF **HEALTHCARE PROFESSIONAL**	PRINTED NAME	DATE SIGNED

☐ M.D. ☐ D.O. ☐ P.A. ☐ R.N ☐ C.N.S. ☐ N.P. ☐ Discharge Planner