

**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 Med-Trans Corporation dba North Colorado Med Evac

(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)
- | | | |
|---|---|---|
| <input type="checkbox"/> Vehicle rollover / ejection / high speed collision | <input type="checkbox"/> Symptomatic hypotension | <input type="checkbox"/> Patient experiencing neurological impairment (CVA, Stroke, Seizures) |
| <input type="checkbox"/> Vehicle striking pedestrian > 10 mph | <input type="checkbox"/> High-risk obstetrical conditions | <input type="checkbox"/> Symptomatic hypertension |
| <input type="checkbox"/> Falls from > 15 feet | <input type="checkbox"/> Penetrating trauma | <input type="checkbox"/> Major burns of the body surface area; burns involving the face, hands, feet, perineum; burns with significant respiratory involvement; major electrical or chemical burn |
| <input type="checkbox"/> Motorcycle victim ejected at > 20 mph | <input type="checkbox"/> Spinal Cord / spinal column injury | <input type="checkbox"/> Same vehicle fatality |
| <input type="checkbox"/> Near drowning injuries | <input type="checkbox"/> Partial or total amputation | |
| <input type="checkbox"/> Major crush injuries | <input type="checkbox"/> 2 or more long bone fx. Pelvic fx, | |
| <input type="checkbox"/> AMI / Chest pain | <input type="checkbox"/> Altered level of consciousness | |
| <input type="checkbox"/> Other (specify) _____ | | |

Specialty Care Required

- Specialty Care likely required for this patient's immediate care. **(Please check the appropriate physician consultation or skill likely required)**
- | | | |
|---|--|---|
| <input type="checkbox"/> Cardiologist | <input type="checkbox"/> Pulmonologist | <input type="checkbox"/> ICU Not Available at referring |
| <input type="checkbox"/> Cardiothoracic Surgeon | <input type="checkbox"/> Gastroenterologist | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Vascular Surgeon | <input type="checkbox"/> Neonatologist | _____ |
| <input type="checkbox"/> Neurologist | <input type="checkbox"/> Pediatric Intensive Care Specialist | _____ |
| <input type="checkbox"/> Neurosurgeon | <input type="checkbox"/> Burn Specialist | _____ |
| <input type="checkbox"/> Neuroradiologist | <input type="checkbox"/> Trauma Surgeon | |

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: North Colorado Med Evac. 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