Instructions: Complete Part A for all Transports and B **OR** C

A. 1. Transportation from: ______________________ to ______________________
2. Date of Service: ___ /___ /___ Discharged from ☐ Yes ☐ No
Admitted to second facility ☐ Yes ☐ No
3. Round Trip ☐ Yes ☐ No

Complete B or C

B. 1. Transport by (check one)
☐ **MEDICAB** - no care, treatment, or medical monitoring indicated

or

☐ **WHEELCHAIR VAN** - no care, treatment, or medical monitoring indicated

PHYSICIAN SIGNATURE: ______________________ DATE: ___ / ___ / ___

PHYSICIAN NAME PRINTED: ______________________

C. AMBULANCE TRANSPORTS

1. Transfer by ambulance - care, treatment, or medical monitoring is indicated
2. Specific medical condition(s) requiring the use of an ambulance at the time of transport: ______________________

____

3. Reason(s) that other methods or transportion are contraindicated at the time of transport:
(check all that apply)

☐ bed confined before and after transport
☐ monitor & maintain patient's airway
☐ cardiac monitoring necessary
☐ Suction prn
☐ med administration / iv therapy
☐ administer oxygen prn / patient unable to self administer
☐ special handling / equipment required to safely move patient
☐ Observe for change in mental status
☐ other care required ______________________

☐ patient unable to get out of bed without assistance
☐ monitor vital signs
☐ assess patient / reassess patient / treat prn
☐ patient must be restrained
☐ patient required special handling - morbid obesity
☐ patient requires special handling - isolation / infection control
☐ patient requires positioning / repostioning during transport
☐ patient requiring monitoring, patient safety (ie, dementia, restless, etc)

4. Physician's certification of medical necessity for ambulance service:
I certifiy that transportation by means other than ambulance is contraindicated by the medical conditions described above.

Is the transport being done to closest available facility ? ☐ Yes ☐ No

PHYSICIAN SIGNATURE: ______________________ DATE ___ / ___ / ___

PHYSICIAN NAME PRINTED: ______________________

TRANS AM AMBULANCE SERVICES INC. 1658 OLEAN PORTVILLE RD. OLEAN, NY 14760 CERTIFICATE OF MEDICAL NECESSITY FOR AMBULANCE TRANSPORTATION	Patient Name