Please verify that PCS is complete before leaving the hospital. Please verify that all highlighted area's are complete.

Run# **(Crew responsibility)**		**Place patient sticker here**

Tri-Hospital E.M.S.
309 Grand River – Port Huron, Michigan 48060 Phone : (810)985-7115 Fax : (810)985-3012

CERTIFICATION STATEMENT

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

_____

Is patient BED Confined? ❑Yes ❑No **CMS Definitioin :** 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**
- ❑ 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 _____
- ❑ Decreased level of consciousness:
- ❑ Psychiatric: **Diagnosis** _____

- ❑ Patient has amputations. **Specify :** _____
  ___ Above the knee ___ Below the knee ___ Unilateral
- ❑ Requires IV maintenance ❑ Seizure prone
- ❑ Patient given SEDATIVES or NARCOTICS prior to transport
- ❑ Patient given Oxygen _____**LPM** *Unable to self admin/No unit*
- ❑ Unable to be transported in a seated position due to _____
- ❑ E.K.G. Monitoring Required

❑Dementia ❑Lethargic ❑Altered Mental Status ❑Comatose
❑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.
SIGNATURE – 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.

X		
SIGNATURE OF HEALTHCARE PROFESSTIONAL	**PRINTED NAME**	**DATE**

❑ **MD** ❑ **PA** ❑ **R.N.** ❑ **C.N.S.** ❑ **L.P.N.** ❑ **Social Worker** ❑ **Case Manager** ❑ **DISCHARGE PLANNER** ❑ **D.O.** ❑ **N.P.**