EXCELSIOR SPRINGS FIRE DEPARTMENT
Ambulance Transfer Worksheet & Physicians Certification Statement

Patient Name _____ Date of Service _____/_____/_____

Location of Pick-up _____

Destination _____

TRANSFER WORKSHEET:

1) The patient is being transported for:
☐ Discharge (indicate reason for stay) _____
_____
☐ Patient convenience/preference (**explain below**)
☐ For a higher level of care (**explain below**)
☐ Cardiac Catheterization (not available at current facility.)
☐ Extended in-patient mental health services unavailable at current facility.
☐ Local specialist is unavailable to provide needed treatment (**explain below**).
☐ Complicated patient (**explain below**).

Explanation _____

_____

2) Continuing Medical Condition at time of transport that necessitates ambulance:
☐ Needs continuous oxygen (**explain below)**
☐ Needs restraints (**explain below**)
☐ Has unset or in-operable fracture (**explain below**)
☐ Has orthopedic or other device – must stay immobile
☐ Patient was sedated prior to transport
☐ Other (**explain**)

Explanation _____

_____

3) Physical Condition at time of transport that necessitates ambulance transport
☐ Bed confined
- ☐ unable to get out of bed without assistance
- ☐ unable to ambulate
- ☐ unable to sit in a chair or wheel chair

Mark any of the following that apply
☐ Contracted
☐ No purposeful movement
☐ Fetal position
☐ Bed sores
☐ Patient has acute disabling weakness (**explain**)
☐ Patient has acute disabling pain (**explain**)
☐ Patient cannot support self in sitting position for the length of transport.
☐ Patient is a danger to self or others
☐ Patient has a decreased level of consiousness – needs monitoring

Explanation _____

_____

(01/15/2008)

4) Insurance and payment information (FOR NON-EMERGENT TRANSPORTS ONLY)
☐ Medicare B
☐ Medicare HMO
☐ Medicaid
☐ Medicaid HMO
☐ Hospice (indicate Hospice Program Name) _____
_____
☐ Private/Group Insurance – Co. Name _____
☐ Patient has VA (**Contact VA travel depart to secure transport authorization**) Authorization # _____
_____.
☐ Patient/Family is paying (**responsible person must be present or reachable to secure authorization for transport/payment)**

PHYSICIANS CERTIFICATION STATEMENT:
(PCS IS ONLY REQUIRE FOR NON-EMERGENT TRANSPORTS.)

A Physician Certification Statement (PCS) is required, pursuant to 42 C.F.R. 410.40 (d)(2) and (3), by the Centers for Medicare and Medicaid Services (CMS) on all non-emergency transports. **THE ORIGINAL COPY OF THIS FORM MUST BE GIVEN TO THE AMBULANCE CREW TRANSPORTING THE PATIENT.**

Instructions: A physician, nurse practitioner, physicians assistant, registered nurse or clinical nurse specialist employed by the facility where the patient is being treated, who has knowledge of the patient's condition at the time of transport is ordered, may sign the PCS.

PHYSICIANS STATEMENT: In my professional opinion, this patient requires transportation by ambulance and should not be transported by other means. The patient's condition is such that transportation and observation by medically trained personnel is required. I certify that the information provided within the Transfer Worksheet and PCS is true and correct based on my evaluation of this patient. I understand that this information will be used by CMS, V.A., Private or Group Insurance Companies, and Excelsior Springs Fire Department to support the determination of medical necessity for ambulance service.

_____
Signature

_____
Printed name

Date Signed _____/_____/_____