



Certification for Medical Necessity of Ambulance Transport

Required for Non-Emergency Medical Transportation Services

Transport Date: ___/___/___

Expiration Date (Max. 60 days): ___/___/___

_____ requires E.M.T. staffed transport for the following medical reasons:

Patient Name _____

Primary Diagnosis _____ Secondary Diagnosis _____

- Bed confined before and after transport due to 1) inability to get out of bed without assistance, 2) unable to ambulate **AND** 3) is unable to support themselves safely and/ or is unable to tolerate a wheelchair. (All 3 requirements must be met at time of transport)
- Requires medical supervision and vital signs monitoring during transport.
Why: _____
- IV monitoring required during transport.
- Airway monitoring and/or Respiratory suctioning required during transport.
- Neurological monitoring required during transport.
- Oxygen administration that may require an adjustment in the doses of oxygen during transport in an EMT staffed ambulance.
- 5150 Hold requiring EMT staffed ambulance / Restraints Required / Agitated Patient
- Immobilization of fracture and required special skills to maintain immobility and/ or positioning. Specialized device used for positioning: _____
- Patient is comatose and requires trained monitoring.
- Requires isolation precautions (VRE, MRSA, etc.)
- Has decubitus ulcers and requires wound precautions
- Other means of transportation would be contraindicated for insuring patient's safety and well being.
- Other condition(s) not listed above: _____

The undersigned authorized representative certifies that he/she is familiar with the patient's condition, has reviewed the foregoing certification and has determined that ambulance transportation is medically necessary for the reasons checked above. Ambulance service is hereby ordered.

Signature of Authorized Representative

Print Name and Title

___/___/___
Date