



Physician Certification Statement
Certificate of Medical Necessity for Ambulance Service
Fax to (904)724-0226

Patient Name _____ SSN _____

Transported To _____ Date _____

Transported From _____ Date _____

Physicians Name _____ Phone _____

Is a return trip necessary (Support Medical Necessity in he notes below) Yes No

Are multiple Transports of this patient expected? (Support in Notes Below) Yes No

Transport by ambulance medically necessary because:

- Restraints Required
Hemodynamically Unstable
S/P MI or Catheterization
Unset Fracture Requiring Stabilization
Requires medically supervised stretcher for transport
Acute CHF, Respiratory Distress or Unstable Angina
Receiving IV therapy or medications during transport
Patient poses a threat of harm to self or others (Baker Act)
Other

Transport by other means other than ambulance (private car, wheelchair or stretcher van) contraindicated based on:

- Need for ALS (defibrillator, medications, etc.)
Need for BLS (medical attendant or restraints)

I certify that the ambulance transport for this patient is medically necessary for the reasons listed above. Transport by other means would be detrimental to the patient's health. An R.N. may sign if the physician has issued a verbal order. Physician must sign at the first available opportunity.

R.N. Signature (Physician order via phone) _____ Date _____

Physician Signature _____ Date _____
(or ARNP, PA)

Print Physician's Name _____

