20475 West Ten Mile Road ◆ Suite 102
Southfield ◆ MI ◆ 48075
Phone: (248) 430 7198/Fax: (248) 301 6927

PATIENT STICKER

TOTAL RESPONSE RUN # _________

PHYSCIANS CERTIFICATION STATEMENT (PCS)

Attending Physician: ________________________ **NPI** _________________ **TRANSPORT DATE:** ____/_____/_____

PATIENTS NAME: ____ **DATE OF BIRTH:** ____/____/______

FROM/ORIGIN: _________________________________ **TO/DESTINATION:** _________________________________

MEDICARE/MEDICAID ID: ______________________ **ROUND TRIP? YES___ NO__** **Repetitive? YES__ NO__**
IF THIS IS A HOSPITAL-TO-HOSPITAL TRANSFER PLEASE DESCRIBE WHAT SPECIALTY WAS NOT AVAILIBLE AT SENDING FACILITY:
____

MEDICAL NECESSITY- MUST BE COMPLETE

Please describe the **MEDICAL CONDITION** of the patient at the time of ambulance transport that necessitates the patient going by ambulance: ____
____

Is patient bed confined? (Must meet all 3 of the following conditions (1) Unable to get up from bed without assistance AND (2) Unable to ambulate AND (3) Unable to sit in a chair or wheelchair) ☐ **YES** ☐ **NO**

If the patient does not meet the bed confined criteria, can the patient be transported safely in a wheelchair van? ☐ **YES** ☐ **NO**

Please CHECK ALL medical conditions that apply to this patient.

☐ Contractures
☐ Non-Healed Fractures
☐ Deep Vein Thrombosis
☐ Decubitus Ulcers
☐ Unable to Tolerate Sitting
☐ Orthopedic Device
☐ Moderate/Severe Pain
☐ Isolation Precautions
☐ OTHER: ____

☐ Confusion
☐ Comatose
☐ Combativeness
☐ Restraints
☐ Danger to self/others
☐ Flight Risk

☐ Cardiac Monitoring
☐ Requires IV maintenance
☐ Hemodynamic Monitoring
☐ Requires Oxygen ___ LPM
*Unable to self-administer
☐ Airway Management or Suctioning

SIGNATURE -PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify that the above information is TRUE and CORRECT based on my evaluation on the patient and represent that the patient requires transport by ambulance and that other forms of transport are contraindicated.

SIGNATURE OF HEALTHCARE PROFESSIONAL	PRINTED NAME	DATE SIGNED

☐ M.D ☐ D.O. ☐ P.A. ☐ R.N. ☐ C.N.S. ☐ DISCHARGE PLANNER