EAGLE III

Phone: 877-332-4533   Fax: 920-884-3006

Run # ______________

Certificate of Medical Necessity for Air Medical Transport

Patient Name: ______________________ Date of Transport: ______________________

Sending Facility: ______________________ Referring Physician: ______________________

Receiving Facility: ______________________ Receiving Physician: ______________________

Transportation by any mode other than by Air Ambulance is contraindicated due to the patient's clinical condition at time of transport for the following reasons: *(Please check all that apply.)*

❑ Time-sensitive intervention is required for the following condition:

___ Cardiac
___ Neurological
___ Respiratory
___ Trauma
___ Burns
___ Unconscious/Shock
___ Severe/Uncontrolled Bleeding
___ OB/GYN
___ NICU (Neonatal ICU)
___ PICU (Pediatric ICU)

❑ Duration of ground transport time would be excessive and potentially detrimental to patient's outcome (>30-60 min)

❑ Obstacles or conditions exist which necessitate Air Medical Transport:

___ Weather
___ Environment
___ Closest Appropriate Facility on Diversion/Bypass
___ Traffic/Road Conditions
___ Disaster Situation
___ Other: ______________________

❑ Higher level of care is required enroute that is not available by ground transport.
Explain: ______________________

❑ Protocols (county/regional/state) recommend Air Medical Transport
Explain: ______________________

❑ During transport, the patient's condition required specialized care:
___ Intubation ___ TPA Infusion ___ IABP ___ ETC02 Monitoring ___ EKG ___ IV Meds/Titrated Drips

❑ Transplant intervention is required for surgery or organ failure
Explain: ______________________

❑ Service is not available at sending facility:

___ Advanced Cardiac/Pulmonary
___ Advanced Neurological Services
___ Certified Primary Stroke Care
___ Other: ______________________
___ Trauma/Burn Unit
___ Orthopedics
___ High-Risk OB
___ Neonatal ICU / Pediatric ICU

❑ Other Reason: ______________________

❑ EMTALA certified transport to appropriate facility and/or higher level of care.

Pursuant to federal COBRA/EMTALA Statute SEC. 1867 [42U.S.C. 1395dd] (A) Social Security Act – Medical Screening Requirement(s) the patient cannot be transferred unless all of the following conditions have been met:

a. The receiving facility has available space, qualified personnel and has the capacity to assume care of this patient;
b. Copies of medical records referring to this patient incident will be provided to the receiving facility;
c. I hereby certify that the above diagnosis, condition(s) and/or physical obstacles to transfer this patient require air medical transport;
d. Based on information/medical expertise available at the time of request for Air Medical Transport, medical benefits reasonably expected from the provision of appropriate medical treatment at the receiving hospital outweigh the risks, if any, to the individual's condition.

This document must be reviewed and completed by: Attending Physician / Physician's Assistant / Nurse Practitioner / Clinical Nurse Specialist / Registered Nurse or Discharge Planner/Social Worker involved in the arrangement of transport.

Referring Provider Signature: ______________________ Date: ______________

Printed Name / Credentials: ______________________