



Miller EMS, PO Box 65, Medford, OK 73759 Ph: 1-877-395-0911 (Fax) 580-395-3912

**Physician Certification Statement for Ambulance Transport**

Please fill out and give to transporting EMS crew

Date of service: \_\_\_\_\_ Patient's Name: \_\_\_\_\_

Transfer Reason / Chief complaint: \_\_\_\_\_

Origin Facility: \_\_\_\_\_

Origin Type: Circle One

Intra-Facility Transfer    Initial Transfer    Return transfer    Other: \_\_\_\_\_

Destination Name: \_\_\_\_\_

Destination Type: Circle One

Hospital    Nursing Home/ Skilled Facility    Other: \_\_\_\_\_

To be completed by the patient's Physician, Physician Assistant (PA), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), Registered Nurse (RN), or Discharge Planner.

PATIENT'S AMBULATORY STATUS

Can patient sit up in chair? Yes \_\_\_\_\_ No \_\_\_\_\_

If patient can sit in chair, how long can patient tolerate sitting? \_\_\_\_\_

If patient is permanently confined to bed, what movement limitations prevent the patient from being able to get out of bed (i.e. location of any paralysis, balance limitations, etc.)

\_\_\_\_\_  
\_\_\_\_\_

What illness created the movement limitations noted in

\_\_\_\_\_

DOES PATIENT REQUIRE OXYGEN Yes \_\_\_\_\_ No \_\_\_\_\_

Does the patient routinely require oxygen? Yes \_\_\_\_\_ No \_\_\_\_\_

For what condition (s)? \_\_\_\_\_

Could patient self administer (hold cannula in place) on his or her own? Yes \_\_\_\_\_ No \_\_\_\_\_

OTHER CONDITIONS

Transfer for specialized care not provided at original facility. Specialized Care: \_\_\_\_\_

Other conditions affected by travel in such a way that without ambulance transfer would bring harm to the patient?

\_\_\_\_\_

What harm might be expected? \_\_\_\_\_

PHYSICIAN, PA, NP, CNS, RN, OR DISCHARGE PLANNER SIGNATURE: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_