

EMS Use Only: Date Received:

Leon County Emergency Medical Services Physician Certification Statement for Ambulance Services

This form must be filled out for any transport from any facility, regardless of the patient's Medicare status; To request a transport Call (850) 606-5808 and Fax to (850) 606-5892.

Patient's Name	SECTION I – GENERAL INFORMATION			
Origin: Rm # Destination: Is the pt's stay covered under Medicare Part A (FPSDRC7) YES NO Closest appropriate facility? VFS NO If no, why is transport roll one of datant facility required? If hosp-hopt transfer, describe services needed at 2" facility not available at 1" facility: If hosp-hopt transfer, describe services needed at 2" facility not available at 1" facility: If hosp-hopt transfer, describe services needed at 2" facility not available at 1" facility: If hosp-hopt transfer, describes services needed at 2" facility not available at 1" facility: If hosp-hopt transfer, describes services needed at 2" facility: If hosp-hopt transfer, describes services needed at 2" facility: If hosp-hopt transfer, described to provide the patient of the facility: If hosp-hopt transportation is medically necessary only if other means of transport are countriadicated by potentially harmful to the patient. To accet this requirement, the patient must be their Productions of the medical professional signals before for this form to be valid. Describe the MEDICAL CONDITION (ghysical and/or mental) of this patient and the transported in an ambulance is contraindicated by the patient's condition: The following questions and why transported by other means to contraindicated by the patient's condition: To be 'bed confined' as defined below?	Patie	ent's Name: Date of Birth: Medicare #:		
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Closest appropriate facility? YES NO If no, why is transport to more distant facility required? If hosp-hosp transfer, describe services needed at 2" facility not available at 1" facility; If hosp-hosp transfer, describe services needed at 2" facility not available at 1" facility; If hosp-hosp transfer, describe services needed at 2" facility not available at 1" facility; If hosp-hosp transfer, describe services needed at 2" facility not available at 1" facility; If hosp-hosp transfer, described to the contraind of the patient of the contraind of the contraint of the contra	Origin: Rm #Destination:			
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Section II - Medical Necessity Questions and patients is nedically necessary only if other means of transport accounts indicated by would be potentially harmful to the patient. To meet this organization is medically necessary only if other means of transport accounts indicated by would be potentially harmful to the patient. To meet this organization is medically necessary only if other means of transport accounts indicated by the patient must be time "red confined" by a suffer from a condition out that transport the mean and buliance is contransdictated by the patient is condition. The following questions must be answered by the medical professional signing below for this form to be valid! Describe the MEDICAL CONDITION (polysical and/or mental) of this patient AT THE TIME OF AMBILIANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means is contransdictated by the patient's conditions. Describe the MEDICAL CONDITION (polysical and/or mental) of this patient AT THE TIME OF AMBILIANCE TRANSPORT that requires the patient to be transported by an arrival transport of the patient must satisfy all three of the following conditions: (1) unable to get up from bed without Assistance, AMD (2) unable to arbital teach of the international professional significant professional significant professional professional professional professional significant professional pro	Closest appropriate facility? YES NO If no, why is transport to more distant facility required?			
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Run#_

Med Unit:_

Controller: