



# NORTH CENTRAL EMS & RESCUE SQUAD

## Physician's Certification Statement (PCS)

24 Hour Dispatch: (877) 37-NCEMS (6-2367) Business Office: (262) 729-9886

STATEWIDE TRANSPORT  
Racine County  
Kenosha County  
Walworth County  
Milwaukee County  
Waukesha County

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Transport Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Referring Physician: \_\_\_\_\_  
Location address/Facility Address/Facility  
Patient Picked Up: \_\_\_\_\_ Transported to: \_\_\_\_\_

1) Qualifying documentation supporting presumptive reasons that non-emergency ground transport by any other means than ambulance is contraindicated. Supporting documentation for any boxes checked must be maintained in the patient's medical records. Personal vehicle, taxi or wheelchair van would not be appropriate because: Check ALL that apply.

- Bed Confined \* ALL THREE must be met to qualify for bed confinement: 1) Unable to ambulate; 2) Unable to get out of bed without assistance; 3) Unable to safely sit up in a wheelchair
- Unable to maintain erect sitting position in a chair for the time needed to transport, due to moderate muscular weakness, de-conditioning or no upper body control.
- Assistance required to apply or regulate oxygen en route.
- Chest Tubes
- Contractures
- Unconscious
- Trauma
- Confused, combative, lethargic, comatose
- Isolation Precaution List: \_\_\_\_\_
- Trach w/O2 / Suction needs
- DVT requires elevation of lower extremity
- Restraints (physical or chemical) anticipated or used during transport.
- Other/condition \_\_\_\_\_
- Moderate to severe Pain on movement
- Danger to self or others-monitoring
- Flight risk
- Drug or IV administration/monitoring
- Decubitus ulcers Stage \_\_\_\_\_ Location \_\_\_\_\_
- Medicated for transport with: \_\_\_\_\_
- Morbid obesity requires additional personnel/equipment to handle
- Risk of falling off wheelchair or stretcher while in motion. (not related to obesity)
- Non healed fractures
- Cardiac Care
- Ventilator Dependent

2) **Hospital to Hospital ONLY:** Please indicate what service/treatment is needed that the sending facility cannot provide:  
\_\_\_\_\_  
\_\_\_\_\_

3) At time of transport was patient discharged from sending facility?  Yes  No

4) Behavioral Health Is the patient currently under a psychiatric hold?  Yes- Duration: \_\_\_\_\_  No

The ambulance transport benefit under Medicare covers a medically necessary transport of a beneficiary by ambulance to the nearest appropriate facility that can treat his or her condition when any other methods of transportation are contraindicated.

I certify that the above information is true and correct based on my evaluation of this patient to the best of my knowledge and professional training. I understand that this information will be used by the Department of Health and Human Services and Medicare to support this determination of medical necessity for ambulance services. I further certify that our institution has furnished care or other services to the above named patient. In the event that you are unable to obtain the signature of the patient or another authorized representative, pursuant to 42 C.F.R. §424.36(b)(4), I hereby sign on the patient's behalf.

**CHECK CREDENTIALS THAT APPLY**

Physician,  Physician Assistant,  Nurse Practitioner,  Clinical Nurse Specialist,  Registered Nurse or  Discharge Planner.

Signature of Physician or Health Care Professional \_\_\_\_\_ Phone Number \_\_\_\_\_ Date Signed \_\_\_\_\_

Print Name \_\_\_\_\_ Fax Number \_\_\_\_\_

PLACE PATIENT ID STICKER HERE