For Use in Hospital, Clinic, Urgent Care, and POB settings

For AAS use only:
AR#_____ Unit # _____ Date_____

Albuquerque Ambulance Service Physician Certification Statement (PCS) Form.

Transfer Information Form

STEP 1:

INFORMATION REQUIRED FOR TRANSFERS	
Facility Name:	Age of patient: Sex: M / F
Department:	Room Number:
Sending Provider Name: Sending Provider/Facility Phone #:	Receiving Provider Name: Receiving Provider/Facility Phone #:
Explain specifically what is going on with the patient and why they need to be transferred:	
Is patient breathing? YES / NO	
Is patient awake (conscious)? YES / NO	
Is this a sudden or unexpected change in patient mentation? YES / NO	
Does the patient have any significant bleeding or shock symptoms? YES / NO	
Is the patient in severe pain? YES / NO Is it chest pain? YES / NO	
If YES, does the patient require a lights and sirens response? YES / NO	
Will any special equipment be necessary? YES / NO If YES, Circle: Oxygen Cardiac Monitor Restraints Isolation Ventilator Fetal Heart Monitor Isolette/Baby Pod INT/Saline Lock IV IV pump/medications (how many?) Other _____	
Medication name(s): _____ **(If medications are being transported, see "Transfer Medications" section at end of form)**	
Will additional personnel be needed? YES / NO If Yes, why? _____	
Is the Physician or APC OK with downgrading the ambulance to a Code 1 response (no lights and sirens)? YES / NO	
STOP HERE IF THE PATIENT'S CLINICAL CONDITION INDICATES A LIFE OR LIMB-THREATENING EMERGENCY. NO MORE INFORMATION IS NEEDED. CALL ALBUQUERQUE AMBULANCE DISPATCH (505) 761-8200	

STEP 2:

INFORMATION FOR STAT RESPONSE ONLY. (EMERGENT)
Is the patient over 250 pounds? YES / NO If yes, is the patient over 500 pounds? YES / NO
Does the patient's clinical condition indicate that s/he needs to be transported within the next 30 minutes? YES / NO If yes, can you describe what makes this a STAT request (transport less than 30 minutes)?
What is the patient's destination (facility)?
What is the department?
What is the room number (if not the ED, Cath Lab or OR)?
STOP HERE IF THE PATIENT'S CONDITION INDICATES TRANSPORT IS REQUIRED WITHIN 30 MINUTES. NO MORE INFO IS NEEDED. CALL AAS DISPATCH AT (505) 761-8200

STEP 3:

NON-EMERGENCY/SCHEDULED RESPONSE.	
Patient Name:	Date of Birth:
Social Security Number:	Insurance Plan:

CONTINUED ON BACK SIDE

Place Patient ID Sticker Here

Provider's Certification Signature

(This boxed section MUST be filled out by the sending facility's authorized personnel. All FIELDS MUST BE COMPLETE.)

The PCS for repetitive transports must be signed and dated **by the attending physician** before furnishing the services to the patient.

In my professional medical opinion, this patient requires transport by ambulance and should not be transported by other means. The patient's condition is such that transportation by medically trained personnel is required, to the best of my knowledge and professional training.

(Required checkboxes below: MUST select at least one box, *OR* both for non-emergency transports)

☐ I hereby certify that the patient's medical condition is such that other means of transportation would be contraindicated/or the patient's medical condition, regardless of bed confinement is such that transportation by ambulance is medically required.

☐ (Click this checkbox for non-emergency ambulance transports ONLY)

I certify that: **(1)** The beneficiary is unable to get up from bed without assistance.

(2) The beneficiary is unable to walk (ambulate); and

(3) The beneficiary is unable to sit in a chair or wheelchair.

Provider/Representative Printed Name (Required):_____

Signature (Required):_____ Date (Required): _____

REQUIRED: Below you must select the correct title for the person signing this form.

MD____ PA____ NP____ CNS____ RN____ LPN____ Social Worker___ Case Manger____ Discharge Planner____

Transfer Medications - This section must be filled out if a medication will be monitored during transport.

Medication #1 Name _____ Indications For Med_____

Drug Name (From Pump)_____ Dose _____

Patient Weight In kg_____ Rate_____

Concentration_____ VTBI_____

Confirmed By Sending RN (Initial) _____ Confirmed By AAS Provider (Initial)

☐ EMT/Paramedic May Monitor Only. May Not Make Any Adjustments

☐ EMT/Paramedic May adjust medication w/in the following parameters: _____

☐ EMT/Paramedic May Discontinue this medication under these conditions:_____

Medication #2 Name _____ Indications For Med_____

Drug Name (From Pump)_____ Dose _____

Patient Weight In kg_____ Rate_____

Concentration_____ VTBI_____

Confirmed By Sending RN (Initial) _____ Confirmed By AAS Provider (Initial) _____

☐ EMT/Paramedic May Monitor Only. May Not Make Any Adjustments

☐ EMT/Paramedic May adjust medication w/in the following parameters: _____

☐ EMT/Paramedic May Discontinue this medication under these conditions:_____

MD Name _____ MD Signature _____

Contact Number _____ Patient Name _____

***NARCOTIC ANALGESIC INFUSIONS MAY NOT BE TRANSFERRED FROM FACILITY TO EMS PROVIDER; AAS MAY ONLY ADMINISTER PUSH DOSES OF NARCOTIC ANALGESICS DURING TRANSPORT. IF NARCOTIC INFUSIONS ARE REQUIRED, CCT MUST BE UTILIZED.**

***IF MORE THAN TWO MEDICATIONS MUST BE MONITORED DURING TRANSPORT, PLEASE USE AN ADDITIONAL FORM.**

***Certain medication must be attended by a Critical Care Transport Unit or an RN during Transport.**

***Medications that require titration during transport must be attended by a Critical Care Transport Unit or an RN during transport. If you have any questions, please call the AAS supervisor at (505)449-5745 or (505)362-8105/06.**