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

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

Albuquerque Ambulance Service Transfer Information Form/Physician Certification Statement

STEP 1: REQUIRED INFO FOR ALL TRANSFERS	
Facility Name:	Age of patient: Sex: M / F
Department:	Room Number:
Sending Provider:	Receiving Provider:
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: STAT RESPONSE
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 INFORMATION IS NEEDED. CALL ALBUQUERQUE AMBULANCE 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 box MUST be COMPLETELY filled out by sending facility.)

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.

- ☐ I hereby certify that the patient's medical condition is such that other means of transportation would be contraindicated.
- ☐ (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:_____

Signature:_____ Date: _____

☐ MD ☐ PA ☐ NP ☐ CNS ☐ RN ☐ 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 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 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.
***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.

STOP HERE. NO MORE INFORMATION IS NEEDED. ENTER THIS INFORMATION INTO MOBILE CARE CONNECT IF ED Request. IF UNABLE TO UTILIZE MOBILE CARE CONNECT, CALL ALBUQUERQUE AMBULANCE DISPATCH AT (505) 761-8200