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

Albuquerque Ambulance Service - Physician Certification Statement (PCS) Form and Transfer Information Form

Patient Name and Info

Patient Name Prefix | Patient First Name* | Patient Middle Name | Patient Last Name* | Patient Name Suffix

Insurance Plan* | Patient Date of Birth* | Patient Sex: M / F*

Insurance Group ID | Age of Patient:* | Social Security Number

Age of Patient less than 1 year:

AAS PCS Form - Information Required for Transfers - Section 1

Sending Facility Name: * | Department:* | Room Number:* | Is this a Presbyterian Facility?*

Sending Provider Name (first and last) :* | Receiving Provider Name (first and last) :*

Sending Provider/Facility Phone Number:* | Receiving Provider/Facility Phone Number:*

What is the patient's facility destination?*

Explain specifically what is going on with the patient and why they need to be transferred. List service(s) that cannot be provided in the current setting.*

Reason(s) that non-emergency ground transport by ambulance is required. Supporting documentation for any checked item must be maintained in the patient's medical record. Check all that apply. Give specific detail in textbox under each section checked.

☐ Mobility*
☐ Wound
☐ Musculoskeletal
☐ Cardiovascular
☐ Neurological
☐ Mental/Behavioral
☐ Attendant required during transport/Ambulance Transport Required
☐ Other

AAS PCS Form - Information Required for Transfers - Section 2

Will any special equipment be necessary during ambulance transport?*

Special Equipment

☐ Oxygen
☐ Ventilator
☐ IV/INT
☐ ECG monitoring needed during EMS transport
This selection is not for inpatient telemetry required.
☐ Restraints
☐ Saline
☐ IV pump/medications
How many?
☐ Isolette
☐ Baby Pod
☐ Fetal Heart Monitor
☐ Isolation
☐ Other

Does patient need medications monitored by the EMS crew during ambulance transport? Yes/No*

** If this changes upon EMS arrival, please provide an updated PCS form.

(If medications are being transported, see "Transfer Medications" section at end of form.)

Medication name(s):*

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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.

☐ I hereby certify that 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.

☐ 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 First Name*

Date (required):*

Provider / Representative Last Name*

Provider / Representative Email*

Signature (required) :*

Licensure or Title

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

☐ MD ☐ PA ☐ CNS

☐ LPN ☐ NP ☐ RN

☐ Social Worker ☐ Case Manager ☐ Discharge Planner

Transfer Medications - This section must be filled out if a medication will be monitored during transport. See AAS Transfer Medications and Skills list.

Medications

Medication Name*

Indications For Med*

Confirmed by sending provider (Initial)*

Drug Name (from Pump)*

Dose*

Confirmed By AAS Provider (Initial)

Patient Weight in Kg*

Rate*

Concentration*

VTBI*

REQUIRED: Select all that apply:*

☐ EMT/Paramedic may monitor only. May not make any adjustments

☐ EMT/Paramedic may adjust medication within the following parameters:

☐ EMT/Paramedic may discontinue this medication under these conditions:

MD Full Name (First and Last Names):*

MD Signature*

Contact Phone Number*

***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.**

***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 Dispatch Center at (505)449-5710.**