Reason for Air Medical Transport: Interfacility Transfer

Air Ambulance Transport Provided By: _____

Call #: _____ **DOS:** _____

Patient Name: _____ **DOB:** _____

Clinical Diagnosis(es) Necessitating/Contributing to Transfer: _____

_____

Reason For Transfer

Sending facility lacks CAPACITY to care for patient:

☐ Specialty bed required is not available.

Specify type: _____

Sending facility lacks CAPABILITY to care for patient:

Specialty(ies) required at receiving which are unavailable at sending – please be specific:

☐ _____
☐ _____
☐ _____

Sending Facility: _____
Sending Physician/NP/PA: _____ **MD/DO/NP/PA**
(Print full name) (circle credentials)
Accepting Facility: _____
Accepting Physician/NP/PA: _____
Is this the Closest Facility with the CAPACITY and CAPABILITY required by this patient? ☐ YES ☐ NO
Was any other facility bypassed? ☐ YES ☐ NO
If so, why?: ☐ bed not available ☐ specialist not available ☐ weather/natural disaster/road conditions ☐ traffic ☐ multiple specialties required ☐ destination by protocol (specify):_____
☐ Other _____

Reason for Air Ambulance Utilization

Does the patient require immediate and rapid transport to the Accepting Facility that could not be provided by ground ambulance? Y/N __. If yes, why (check **ALL** that apply)

☐ The time or instability of transportation by ground ambulance threatens the Patient's health or survival
☐ The distance between the Sending and Accepting Facilities would take more than 30 minutes by ground ambulance
☐ Other obstacles (such as heavy traffic) preclude transportation by ground ambulance
Specify: _____
☐ The Sending Facility is inaccessible by ground ambulance
☐ Patient requires critical or specialty care capabilities and/or personnel unavailable from local ground EMS resources

I certify, to the best of my knowledge and professional ability, that I have ordered air ambulance transportation because this patient's condition requires such transportation for the reasons set forth above, and transportation by ground ambulance is contraindicated. I further attest that I have provided stabilizing treatment within the capability of this facility (included on-call specialists) to minimize the health risks to the patient during transfer. By so certifying, I am NOT assuming any financial responsibility for these air ambulance services.

Signature/Title: _____ **Date/Time**: _____

Does the requesting physician have a financial/employment relationship with Global Medical Response or subsidiaries? ☐ Yes ☐ No