



PATIENT IMPRINT

Interfacility Ambulance Transfer Request Form

- Instructions:**
1. This form must be completed by the physician, it will help to identify what type of transport is required
 2. Fax this completed form to the ambulance service provider and provide a hard copy to the transport team.
 3. **ALS/ALS-RN transfers must be conducted by Medic Ambulance (Solano County EOA Provider) 707-644-8989**

Patient Diagnosis: _____ **Patient Allergies:** _____

Medicare/Medi-Cal Physician Certification Statement	
The undersigned practitioner certifies that they have personal knowledge of the patient's condition at the time transport is ordered and is medically necessary as specified above. This is not a guarantee of coverage or payment. (Form may be signed by MD, DO, RN, CM, NP, NS, PA if Medicare. If Medi-Cal , form must be signed by Physician, i.e. MD, DO.)	
Signature _____	Date _____
Printed Name & Credentials _____	NPI Number _____

Patient Condition:	<input type="checkbox"/> Critical	<input type="checkbox"/> Noncritical
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<p style="text-align: center;"><input type="checkbox"/> BLS</p> <p><input type="checkbox"/> Supplemental oxygen Delivery type _____ Rate _____ Medical reason for O2 _____ Reason unable to self-maintain O2 _____</p> <p><input type="checkbox"/> Isotonic IV solution @ TKO rate</p> <p><input type="checkbox"/> 5150 psychiatric hold</p> <p><input type="checkbox"/> Restraints</p> <p><input type="checkbox"/> Dementia requiring behavioral monitoring</p> <p><input type="checkbox"/> Isolation precautions</p> <p><input type="checkbox"/> Aspiration precautions</p> <p><input type="checkbox"/> Sedated, including narcotics within last 30 minutes</p> <p><input type="checkbox"/> Post-surgical positioning or movement precautions (fractures, decubitus ulcers, etc.)</p> <p><input type="checkbox"/> Bariatric patient: Weight: _____ Height: _____</p> <p><input type="checkbox"/> Other devices that require medical monitoring: Explain _____</p>	<p style="text-align: center;"><input type="checkbox"/> ALS (MUST GO TO EOA PROVIDER)</p> <p><input type="checkbox"/> Paramedic level assessment & decision making</p> <p><input type="checkbox"/> IV solution <20 mEq/L of Potassium Chloride (KCL)</p> <p><input type="checkbox"/> Cardiac monitoring</p> <p><input type="checkbox"/> Standby external cardiac pacing</p> <p><input type="checkbox"/> Continuous positive airway pressure (CPAP)</p> <p><input type="checkbox"/> Nebulizer therapy</p> <p><input type="checkbox"/> One or more ALS medications: adenosine, aspirin, atropine, beta-2 agonist bronchodilators, calcium chloride, dextrose, diphenhydramine, epinephrine, fentanyl, glucagon, lidocaine, midazolam, morphine, naloxone, nitroglycerin tablets/spray, sodium bicarbonate</p> <p><input type="checkbox"/> Blood product infusion</p> <p><input type="checkbox"/> Pump infusion of amiodarone, NTG, magnesium, or heparin</p>
<p style="text-align: center;"><input type="checkbox"/> ALS-RN (MUST GO TO EOA PROVIDER)</p> <p><input type="checkbox"/> Nursing level assessment or decision making</p> <p><input type="checkbox"/> Medication(s) other than ALS medications listed above</p> <p><input type="checkbox"/> Medication(s) on an infusion pump not listed in ALS section</p> <p><input type="checkbox"/> Blood product infusion</p>	<p style="text-align: center;"><input type="checkbox"/> CCT</p> <p><input type="checkbox"/> Critically ill or injured – requires physician's initials: _____</p> <p><input type="checkbox"/> Ventilator management</p> <p><input type="checkbox"/> Invasive pressure monitoring devices (ex. CVP, Swan-Ganz, arterial line, ICP monitor, etc.)</p> <p><input type="checkbox"/> Transvenous pacing</p> <p><input type="checkbox"/> Intra-aortic balloon pump</p> <p><input type="checkbox"/> Extra corporeal membrane oxygenation</p> <p><input type="checkbox"/> High-risk L&D that may lead to neonatal critical care</p> <p><input type="checkbox"/> Neuromuscular blocking agents</p> <p><input type="checkbox"/> Continuous infusion of sedative agents (ex. propofol)</p>

Requested response level:

<input type="checkbox"/> STAT	<input type="checkbox"/> Scheduled (1-4 hrs)
<input type="checkbox"/> Immediate (60 min)	<input type="checkbox"/> Planned (4-72 hrs)

Additional Doctor's Orders:

PALS/ACLS/NRP protocols

If patient needs services not available at sending facility, please specify: _____

See attached order sheet for additional orders Other orders _____

EMS Time of Request _____ EMS Time of Arrival _____

Receiving Facility _____

Receiving Physician _____ Date and Time _____