Oklahoma HealthCare Authority

Physician's Certification Statement

Patient:_____ Run#:_____

Medicare#:_____ Date of Service:_____

Origin:_____ Destination:_____

Level of Care Required:

1. Is the treatment for which the patient is being transferred available at the hospital of origin? Yes☐ No☐
2. If treatment is not available, what is the specific service(s) for which the patient is being transported?

Patient's Ambulatory Status:

1. Can the patient sit up in a chair? Yes☐ No☐
2. If patient can sit in chair, amount of time patient can tolerate sitting: _____
3. If patient is confined to bed, what movement limitations prevent the patient from getting out of bed (i.e. location of any paralysis; balance limitations; etc.)?

   _____
4. What illness created the movement limitations in #3?

   _____

Does the patient require O2 for this transport? Yes☐ No☐

1. For what condition is it required? _____

Other Conditions:

1. Other conditions affected by travel in such a way that without ambulance transportation, harm would come to the patient: _____

2. What harm might be expected? _____

Signature _____ Title_____ Date_____

ONLY A PHYSICIAN, RN, DISCHARGE PLANNER, PHYSICIAN ASSISTANT, NURSE PRACTIONER, OR CLINICAL NURSE SPECIALIST CAN SIGN THIS FORM

_____

Name Printed

TO BE COMPLETED BY AMBULANCE: MILES TRAVELED ONE WAY:

PLEASE COMPLETE AND SIGN THIS FORM AND GIVE TO TRANSPORTATION PROVIDER