

# LifeTeam

## Physician Certification Statement

Date: \_\_\_\_\_ Mission#: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

### Air Medical Transport Required

- Patient's condition is **TIME CRITICAL**, requiring rapid arrival to minimize morbidity/mortality.
- During transport, patient's condition required critical care life support & monitoring by an ALS crew with an attending RN present (specify care)
  - Intubated     ETCO2 Monitoring     EKG     IABP
  - IV Meds     TPA Infusion     Other: \_\_\_\_\_
- Ground Transport would be hazardous to this patient, or delayed due to:
  - Traffic Conditions     Adverse Weather Conditions

### Interfacility Transfer Required

The healthcare facility in which the patient is located does not have:

- Specialized Trauma 1 Trauma Services
- Specialized Cardiac Services (i.e.: interventional cardiac & open heart svces)
- Specialized Neonatal/Maternal services required for this patient
- Other specialized services: \_\_\_\_\_
- No beds available at the referring facility

### Non-Emergent Ambulance Transport Required

This patient required **NON-EMERGENT** ambulance transport due to:

- Transport by any other means than ambulance is contra-indicated as the patient is unable to walk, stand or sit up due to the following:
  - Severe Contractures
  - Body Cast
  - Other

### Bypass of Closest Facility Required

I have ordered this patient be transported to a facility that can provide services not available at this facility. I acknowledge there may be a closer facility with similar services and am ordering a bypass for the following reason(s):

- Specialist(s) available to manage the complexity of this patient's condition.
- Specialized equipment available to provide appropriate level of care for this patient's specific condition.
- Treatment by physician/specialist with unique knowledge of this patient's specific medical history/condition.
- No beds/accepting physician available at closer facility.
- Other: \_\_\_\_\_

\_\_\_\_\_  
Signature of ordering/authorizing physician

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Printed name of ordering/authorizing physician