Transport Request Form

Patient Identification Label

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____

Medical Record # _____

Midwest Medical Transport (MMT) is working toward future integration of an online transport request system (SAM) that will interface with Epic. Until SAM is fully integrated, follow these instructions to request transport.

1. Apply patient sticker to both sides of this form.
2. **Call MMT Dispatch at 703-829-6855** to request transport unit.
3. Complete front and back of this form. The sending provider should complete the back and sign at the bottom.
4. **Fax the following to 703-827-1229:** Facesheet, Transport Request Form (front and back) and any additional necessary information.
5. Notify MMT Dispatch by phone call if unable to obtain facesheet.

Requestor Name: _____ **Requestor Call Back Phone #** _____

Indicate Transport Type (request to arrive goals in parentheses):

☐ **STAT** (less than or equal to 20 minutes)
☐ **Urgent/Non-Emergency** (within 1-2 hours)
☐ **Emergent/Immediate** (less than or equal to 60 minutes)
☐ **Non-Urgent** (less than or equal to 2 hours)

Response time delays and other issues should be escalated to the MMT leader on duty at **703-829-6855**.

For Urgent/Non-Emergency and Non-Urgent Requests ONLY:

Is patient transferring to a lower level of care: ☐ Yes ☐ No

If yes, has pre-authorization been obtained? ☐ Yes ☐ No

Date and time of desired pickup: (date) _____ (time) _____ : _____ ☐ AM ☐ PM

Ensure after visit summary (AVS) is printed for transport team for patients discharging to another level of care.

Pickup Location:

Sending Campus: _____ Floor: _____

Building: _____ Room # _____

Is patient weight greater than 750 pounds? ☐ Yes ☐ No

Is patient in isolation? ☐ Yes ☐ No Type: _____

Nurse to nurse call? ☐ Yes ☐ No

Destination Location:

Receiving Location: _____

Building/Address: _____

_____

Floor (if applicable): _____

Room # (if applicable): _____

Neuro Status, Vitals and Oxygen:

Neuro: ☐ Alert ☐ Not Alert
☐ Oriented ☐ Disoriented

Blood Pressure: _____ / _____

Heart Rate: _____

Respirations: _____

Oxygen Saturation: _____ % on _____ (flow)

☐ Hi Flow Nasal Cannula

☐ Non-rebreather

IV Access (type and location)**:**

1. _____
2. _____
3. _____

Drips and Medications:

1. _____
2. _____
3. _____

Devices:

☐ Arterial Line	☐ Endo Tubes	☐ Restraints	☐ Wound VAC
☐ Bair Hugger	☐ External Fixator	☐ TR Band	☐ Other: _____
☐ BiPAP / CPAP	☐ Femoral Sheath	☐ Transvenous Pacer	
☐ C-Collar	☐ PCA/CADD Pump	☐ VAD	

Transport arrival for pickup: (date) _____ (time) _____ : _____ ☐ AM ☐ PM

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STAT	• Imminent loss of life or limb • Depart sending facility within 30 minutes
Emergent	• At significant risk of decompensation or death without rapid evaluation • Depart sending facility within 1-2 hours
Urgent	• Timely transfer required but lower risk of decompensation • Depart sending facility within 2-6 hours
Non-Urgent	• Delays in transfer unlikely to have clinical consequence • May be medically necessary or patient preference

Section I – Reason for Transfer

Is patient transferring to the closest appropriate facility? ☐ Yes ☐ No If no, reason for transfer: _____

If hospice patient, is transport related to patient's terminal illness: ☐ Yes ☐ No Describe: _____

For this form to be valid: Sections II and III must be completed and form must be signed by a physician or other authorized healthcare professional.

Section II – Medical Necessity Questionnaire

Ambulance transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than an ambulance is contraindicated by the patient's condition.

1. Describe the medical condition (physical and/or mental) of this patient at the time of ambulance transport that requires the patient to be transported in an ambulance, and why transport by other means is contraindicated by the patient's condition:

   _____

2. Is the patient "bed confined" as defined below? ☐ Yes ☐ No

   To be considered "bed confined" the patient must satisfy all three of the following criteria: (1) unable to get up from bed without assistance, AND (2) unable to ambulate; AND (3) unable to sit in a chair or wheelchair.

3. Can this patient safely be transported by car or wheelchair van? ☐ Yes ☐ No
   (i.e., may safely sit during transport with an attendant or monitoring)

4. In addition to completing questions 1-3 above, check any of the following conditions that apply*:

   ☐ Contractures ☐ Non-healed fractures ☐ Patient is confused ☐ Patient is comatose
   ☐ Danger to self/others ☐ IV meds/fluids required ☐ Patient is combative ☐ Medical attendant required
   ☐ Moderate/severe pain on movement ☐ Need/possible need for restraints
   ☐ Requires oxygen – unable to self-administer ☐ Cannot tolerate seated position for transport time
   ☐ Cardiac monitoring required enroute ☐ Hemodynamic monitoring required enroute
   ☐ DVT requires elevation of a lower extremity
   ☐ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds
   ☐ Morbid obesity requires additional personnel/equipment to safety handle patient
   ☐ Special handling/isolation/infection control precautions required
   ☐ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring specialized handling during transport
   ☐ Other (specify):_____

***Note:** Supporting documentation for any boxes checked must be maintained in the patient's medical record.

Section III – Signature of Physician or Other Authorized Healthcare Professional

I certify that the above information is accurate based on my evaluation of this patient, and that the medical necessity provisions of 42 CFR §410.40(e)(1) are met, requiring that this patient be transported by ambulance. I understand this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services. I represent that I am the beneficiary's attending physician, or an employee of the beneficiary's attending physician, or the hospital or facility where the beneficiary is being treated and from which the beneficiary is being transported, that I have personal knowledge of the beneficiary's condition at the time of transport, and that I meet all Medicare regulations and applicable state licensure laws for the credential indicated.

☐ **If this box is checked**, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim form and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows:

_____

Physician* or Authorized Healthcare Professional:**

(signature)	(print name)	(credentials)	(date**)
_____	_____	_____	_____

**For scheduled repetitive transport, this form is not valid for transports performed more than 60 days after this date.

***For scheduled repetitive transports, form must be signed only by patient's attending physician.
For non-repetitive ambulance transports, if unable to obtain the signature of the attending physician, any of the following may sign (check the appropriate box):

☐ Nurse Practitioner ☐ Registered Nurse ☐ Physician Assistant
☐ Social Worker ☐ Case Manager ☐ Clinical Nurse Specialist ☐ Licensed Practical Nurse ☐ Discharge Planner