



Medical Necessity for Air Transport

Many in the air medical industry are calling for standard criteria to determine which patients require air transport. The following referral form is used to evaluate a patient's need for air medical transport.

As the physician requesting air ambulance transport, please fill out this form in its entirety in order to justify why air transportation is required. (This information will be provided to third party payers)

(Please fill all blanks and check all that apply)

PHYSICIAN'S REFERRAL FORM

Patient Name: _____ **Date of Service:** _____

Referring Physician: _____

Diagnosis or potential of the patient: _____

Referring Hospital: _____

- Time of transport between critical care units must be minimized
- Needs higher level of care
- The patient's condition must be such that commercial air travel is not medically feasible by a commercial airline.
- Complicated medical history requires transfer to patient's primary physician
- Disaster/triage decision
- Other
- Physician Specialist is required for this patient's care and is not available at this institution.

(Please check the appropriate physician consultation or skill required)

- | | | |
|---|--|---|
| <input type="checkbox"/> Cardiologist | <input type="checkbox"/> Trauma Surgeon | <input type="checkbox"/> Gastroenterologist |
| <input type="checkbox"/> Vascular Surgeon | <input type="checkbox"/> Cardiothoracic Surgeon | <input type="checkbox"/> Pulmonologist |
| <input type="checkbox"/> Neurologist | <input type="checkbox"/> Pediatric Intensive Care Specialist | |
| <input type="checkbox"/> Neurosurgeon | <input type="checkbox"/> Burn Specialist | |
| <input type="checkbox"/> Neonatologist | <input type="checkbox"/> Other (specify) _____ | |

- Intensive care required for this patient which is not available at this institution
- Patient may require an emergency procedure that is not available at this institution. The anticipated procedure is:
 - CABG
 - Emergent catheterization
 - Emergent CT scan to rule out operable lesion
 - Emergent surgery by a specialist not available at this hospital, i.e. neurosurgery, vascular surgery, pediatric surgery, trauma surgery, reimplantation
 - Other (specify)

I certify to the best of my professional ability that this patient's condition warrants air ambulance transportation

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____