



FORM# 1863

Medical Transport Justification

Instructions: This form MUST be completed and signed prior to any MedFlight transport. Give completed forms to MedFlight personnel, or Fax directly to 877-633-2661 TOLL FREE.

Transport Data

Name, Date of Transport, MedFlight Request #, Sending Hospital, Receiving Hospital, City/State

Transport Justification Data

A. The receiving hospital has the following clinical services available at their facility that we are unable to provide at the time of the transport. (Check all that apply)

- Subspecialty intervention for a multi-system trauma, Diagnostics or intervention for a neurological or neurosurgical injury or impairment, etc.

B. The patient has clinical requirements during transport that exceed those provided by ALS/BLS services. (Check all that apply)

- Mechanical ventilation, Invasive arterial, venous or intracranial monitoring, Advanced arrhythmic therapy, etc.

C. (For Air Transport Only- Check all that apply) Air transport is required in order to:

- Minimize out-of-hospital time. Please give details; Provide immediate surgical/procedural intervention. Please give details;

D. Transport Mode

- Helicopter, Mobile ICU

Certification Signature

I certify I have completed this report based upon the information available to me at the time of the patient's examination.

Certification Signature

Printed Name and Title

DATE

- Attending Physician, Physician Assistant, Registered Nurse, Discharge Planner