# 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

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Transport</th>
<th>MedFlight Request #</th>
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<tr>
<th>Sending Hospital</th>
<th>Receiving Hospital</th>
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<th>City/State</th>
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## 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, one MUST be checked in this section)

- [ ] Subspecialty intervention for a multi-system trauma.
- [ ] Subspecialty intervention for an orthopedic injury.
- [ ] Specialized pediatric care for a pediatric injury/illness.
- [ ] High-risk obstetrical services
- [ ] Hyperbaric treatment for toxic exposure or other emergent condition.
- [ ] Level III nursery care for a neonatal emergency.
- [ ] Sepsis
- [ ] Subspecialty intervention for vascular emergency
- [ ] Diagnostics or intervention for a neurological or neurosurgical injury or impairment.
- [ ] Surgical or medical specialist for a gastro-intestinal injury or disease.
- [ ] Reimplantation team for an extremity injury.
- [ ] Burn center care for thermal, chemical or electrical injuries.
- [ ] Invasive diagnostics/intervention for a cardio-thoracic injury or disease.
- [ ] Other (PLEASE DESCRIBE):

### B. The patient has clinical requirements during transport that exceed those provided by ALS/ BLS services. (Check all that apply, one MUST be checked in this section)

- [ ] Mechanical ventilation
- [ ] Invasive arterial, venous or intracranial monitoring
- [ ] Advanced arrhythmic therapy
- [ ] Potential clinical changes
- [ ] Advanced hemodynamic support including IABP or VAD
- [ ] Other (PLEASE DESCRIBE):

### C. (For Air Transport Only- Check all that apply, one MUST be checked in this section) 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**  
**Legibly Printed Name and Title**

**DATE**

Title of person signing:

- [ ] Attending Physician
- [ ] Physician Assistant
- [ ] Registered Nurse
- [ ] Discharge Planner

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