



USE BLACK INK ONLY

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, 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, Advanced arrhythmic therapy, Advanced hemodynamic support including IABP or VAD, Invasive arterial, venous or intracranial monitoring, Potential clinical changes, 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