24 Hour Dispatch Center
(877) 367-4226
Physician Certification Statement for Air Ambulance Transport:

Date: _____ Patient Name: _____ DOB: _____

The following information is required for Interfacility Transports by Bismarck Air Medical:

Referring Facility: _____

Referring Physician: _____

Receiving Facility: _____

Receiving Physician: _____

Reason for Transfer (Diagnosis): _____

Services needed at the accepting facility not available at referring facility: _____

_____

Was this the closest appropriate facility: ___Yes ___No If no, why is the distant facility required? _____

_____

Unless otherwise noted, the receiving facility listed above is the nearest facility to appropriately treat this patient's illness and/or injury. Based on my assessment of the patient and the continued medical/nursing care required, I have ordered air ambulance transport and deem it is medically necessary. Any other means of transportation or use of any other receiving facility and/or physician is contraindicated and would be detrimental to this patient health and safety for the following reasons:

I. Time:
   - The patient's condition is time critical requiring air ambulance transportation in order to minimize morbidity and/or mortality.
   - The patient's condition meets the established criteria for transport based on published standards for appropriate utilization of air ambulance transportation from the EMS, Emergency, Trauma, Surgical, Medical, Pediatric, Neonatal, or Maternal Services.

II. General Criteria:
   - The patient requires critical care or advanced life support (personal, equipment, medications, procedures, monitoring, special equipment and/or care) transport that is not available from the local ground ambulance service.
   - The distance to the closet appropriate facility is too great for the safe and timely transport by ground ambulance.

III. Appropriate Facility:
   - The receiving facility provides specialized care which is not available at the referring facility for further diagnostics and treatment for this patient.
   - The patient's attending physician requests transport to a specific facility based on the medical needs of the patient. The receiving facility has previous medical records where the patient received specialized treatment in the past.

_____ _____

Signature of Physician or Healthcare Professional Date

_____

Printed Name and Credentials of Physician or Healthcare Professional

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