

Reason for Transport

Please check all that apply.

- Pt needs to be restrained
- Pt was in shock or unconscious
- Pt needs oxygen, cardiac monitoring, IV
- Pt needed immobilization (or the possibility) of a fracture
- Pt was experiencing hemorrhage
- Confined to bed at time of transport with left side hemiplegia
- Confined to bed at time of transport with right side hemiplegia
- Confined to bed at time of transport with severe MS
- Confined to bed at time of transport with end stage renal failure
- Confined to bed at time of transport with severe contractures
- Confined to bed at time of transport with para or quadriplegia
- Confined to bed at time of transport with severe arthritis
- Confined to bed at time of transport with senile dementia
- Confined to bed at time of transport with hip/leg fractures
- Confined to bed at time of transport with patient in fetal position
- Confined to bed at time of transport with _____
- Transported between hospitals for treatment not available at original Hosp.
- Transport by stretcher as mental status made them a threat to themselves
- Transport between hospitals due to no beds available at original hospital
- Emergency (Accident)
- Emergency (Injury)
- Emergency (Acute Illness)
- Emergency (Other)
- Sustained acute stroke or MI
- Could only be moved by stretcher because of _____
- PCS form (formerly CMN) attached

Authorization

I authorize the use and disclosure of my Protected Health Information by Monroe Ambulance and Monroe Ambulance's staff and Business Associates for purposes of treatment, payment and healthcare operations. I further authorize payment to Monroe Medi-Trans Inc. ("Monroe Ambulance")/Wyoming County Medical Services of Medicare and/or other insurance benefits relative to services rendered to me by Monroe Ambulance. I authorize anyone who has medical information pertaining to me or documentation needed to determine these benefits or otherwise required to process the claims for these benefits or related services provided to me by Monroe Ambulance now or in the future, to release to the Centers for Medicare and Medicaid Services, its carriers or any other carrier, all information required to determine such benefits and process such claims. I understand and agree that if there is a balance owing Monroe Ambulance after payment of such claim, or there is a co-pay or a denial of such claim by Medicare or by my insurance company, I will be obligated to pay to Monroe Ambulance any amount which remains owed to them for the services rendered. Except in the case of an emergency, by signing this form, I acknowledge that I have been provided with a copy of Monroe Ambulance Service, Inc.'s Notice of Privacy Practices.

Notice of Privacy Practices delivered to patient (Circle One) **Y** N

SECTION I – PATIENT SIGNATURE

The patient must sign here unless the patient is physically or mentally incapable of signing.

X _____
Patient Signature or Mark

If the patient signs with an X or other mark please have a witness sign
X _____
Witness Signature
X _____
Witness Printed Name

SECTION II – AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section only if patient is physically or mentally incapable of signing.

Reason the patient is physically or mentally incapable of signing:

Authorized representatives include only the following individuals (check one):

- Patient's Legal Guardian
- Patient's Health Care Power of Attorney
- Relative or other person who receives government benefits on behalf of patient
- Relative or other person who arranges treatment or handles the patient's affairs
- Representative of agency/institution that furnished care / services / assistance to the patient
- Representative of provider or nonparticipating hospital (only if reasonable efforts were first made to obtain signature of one of the authorized signers listed above.)

I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility for the services rendered.

X _____
Representative Signature

Printed Name of Representative

SECTION III – EMERGENCIES ONLY – AMBULANCE CREW AND FACILITY REPRESENTATIVE SIGNATURES

Complete this section only for emergency ambulance transports if the patient was physically or mentally incapable of signing, and no authorized representative was available to sign on behalf of the patient at the time of service.

Ambulance Crew Member Statement (must be completed by the crew at the time of transport)

My signature indicates that at the time of service the patient was physically or mentally incapable of signing and that none of the authorized Representatives were available or willing to sign on behalf of the patient.

Reason pt incapable of signing _____

Name and Location of Receiving Facility _____ Time at Receiving Facility _____

X _____
Signature of Crewmember

Printed Name of Crewmember

Receiving Facility Representative Signature - The above named patient was received by this facility at the date and time indicated above

X _____
Signature of Receiving Facility Representative

Printed Name and Title of Receiving Facility Representative

Secondary Documentation – If no facility representative signature is obtained the crew must obtain one or more of the following forms of documentation from the receiving facility that indicates that the patient was transported by ambulance on the listed date and time.

- PCR (signed by facility)
- Facility Face Sheet
- Patient Medical Record
- Hospital Log or other facility record.