PAFFORD
MEDICAL SERVICES

WORKBOOK
HANDOUTS
&
FORMS

EPCR / DOCUMENTATION

PAFFORD MEDICAL SERVICES
SHORT FORM

DATE	DISPATCH #	INCIDENT #	UNIT#	REASON FOR DISPATCH

CALLER: ☐9-1-1/POLICE/FIRE ☐HOSPITAL ☐NURSING HOME ☐PRIVATE / OTHER ☐ PHY OFFICE / OTH MED FACILITY ☐ MED ALERT

DISPATCH URGENCY (AR / MS / LA) ☐PRIORITY 1 ☐PRIORITY 2 ☐PRIORITY 3 ☐PRIORITY 4 ☐PRIORITY 5

DISPATCH URGENCY (OK ONLY) ☐CODE 3 (Emergency / Immediate Response) ☐CODE 1 (Non-Emergency / Non-Immediate Response)

TRANSPORT URGENCY ☐CODE 1 (without warning devices) ☐CODE 3 (with warning devices)

PICKUP LOCATION:

DROP OFF LOCATION:

ODOMETER READINGS: PICKUP PATIENT ____ • DROPOFF PATIENT ____ •

********** TIMES **********

INCIDENT / ONSET	PSAP RCVD (OK ONLY)	DISPATCHED	ENROUTE	AT SCENE	AT PATIENT
LEAVE SCENE	**AT DESTINATION**	**IN SERVICE**	**BACK HOME**	**CANCELLED**	

NAME First Middle Last | AGE | DATE OF BIRTH | RACE | SEX | PHONE #

ADDRESS (Mailing) City State ZIP | SOCIAL SECURITY #

ADDRESS (Physical) City State ZIP | DRIVERS LICENSE #

LEGAL GUARDIAN / NEXT OF KIN First Middle Last | RELATIONSHIP | PHONE #

MEDICARE ☐ | MEDICAID ☐ | JOB INJURY YES ☐ NO ☐

INSURANCE COVERAGE ☐ individual ☐ Group ☐ Auto ☐ Worker's Comp | NAME OF INSURED | INSURED PHONE | NAME OF EMPLOYER

INSURANCE CO. 1 Address City State ZIP | POLICY #

INSURANCE CO. 2 Address City State ZIP | POLICY #

MVA / AUTO INSURANCE CO. Address City State ZIP | POLICY #

RECEIVING FACILITY REPRESENTATIVE SIGNATURE

I certify that the above named patient was received by our facility on the date and time set forth on this report.

Signature of Facility Representative

Printed Name of Representative

AMBULANCE CREW

Signature of Primary Caregiver

Printed Name of Primary Caregiver

Printed Name of Secondary Caregiver

☐ REFUSAL OF TREATMENT / TRANSPORT

I hereby voluntarily acknowledge and state that I have been advised of my current physical condition and refuse medical treatment and/or transport by ambulance. I hereby for myself, my heirs, executors, administrators, and assigns forever release and fully discharge, the Provider, its officers, employees, medical consultants, hospitals, servants, contractors, and agents from any an all liability arising from their efforts to assess, treat, care, and/or transport me. **PATIENT UNABLE TO SIGN:** [ ] As an authorized representative for the patient, I hereby refuse care and/or transport for this patient and agree to the terms previously stated herein.

Patient's Signature

Responsible Party/Relationship

Witness

CHIEF COMPLAINT: _____

POSITION PATIENT FOUND –

SCENE REPORT –

EVENTS LEADING TO –

AVPU:	○ Alert ○ Pain Responsive	○ Verbal Responsive ○ Unresponsive	○ Oriented ⇨ ☐ x4 ☐ Person ☐ Place ☐ Date/Time ☐ Event

AIRWAY –	BREATHING -	CIRCULATION -	DISABILITY-

PMH –	ALLERGIES -	MEDICATIONS -

A – ALS ASSESSMENT:

PATIENT INFORMATION –

SIGNS / SYMPTOMS –

ONSET	PROVOKES	QUALITY	RADIATES	SEVERITY	TIME (HOW LONG)

HEAD-TO-TOE EVALUATION:

HEAD -	CHEST -	PELVIS -
EENT -	ABD -	UE -
NECK -	BACK -	LE -

TIME	PULSE	RESPIRATIONS	BP	GLUCOSE	SaO2	EKG RHYTM	GCS
			/				
			/				
			/				
			/				
			/				

SKIN	PUPILS	LUNG SOUNDS	STROKE SCALE	RTS / PTS

MED	DOSE	ROUTE	TIME	SOLUTION	SITE	CATH	RATE	AMOUNT
OXYGEN →								

☐ ALS ASSESSMENT
☐ ASSESSMENT ADULT
☐ BVM VENTILATION
☐ COMBITUBE
☐ CONTROL BLEEDING
☐ CPR
☐ DEFIBRILLATION
☐ DRESSING / BANDAGING
☐ INTUBATION
☐ KED IMMOBILIZATION
☐ NASOGASTRIC TUBE
☐ NASOPHARYNGEAL AIRWAY
☐ OROPHARYNGEAL AIRWAY
☐ RESTRAINTS - PHYSICAL
☐ SPINAL IMMOBILIZATION
☐ SPLINTING
☐ SUCTION AIRWAY
☐ VENTILATOR
☐ _____
☐ _____

Flinders UNIVERSITY

Glasgow Coma Scale (GCS) Assessment

Aim

To safely and effectively assess patient GCS

Indications

A Glasgow Coma Scale (GCS) assessment should be conducted on every patient.

Background

The GCS was developed at the University of Glasgow's Institute of Neurological Sciences. It is numerical rating system, originally used for measuring conscious state following traumatic brain injury, which has become a widely used and recognised assessment tool for reporting any patient's conscious state. The GCS uses three categories that pertain to different areas of a person's conscious state, they are; eyes opening, vocal response and motor response. Each unit is given a range of numbers that correlate with definable levels in consciousness which are then collated to give a GCS between 3 (deep unconscious) to 15 (normal conscious level). The best response is recorded for each category.

Summary of the GCS

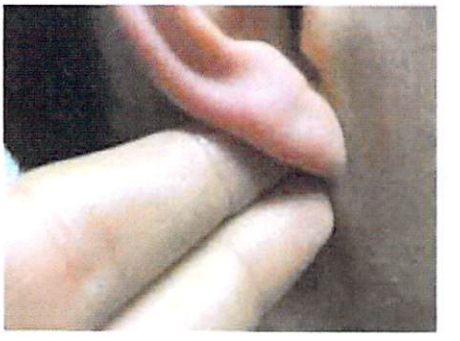
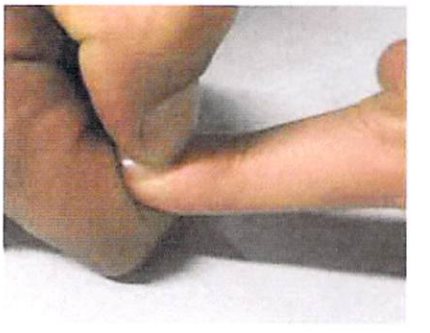
	Eyes Opening		Verbal Response		Motor Response
4	Spontaneous	5	Orientated to time and place	6	Obeys command
3	Voice	4	Confused speech	5	Localises to pain
2	Pain	3	Inappropriate words	4	Withdraws to pain
1	None	2	Incomprehensible sounds	3	Decorticate
		1	None	2	Decerebrate
				1	None

Score: 14 - 15 = mild dysfunction

Score: 11- 13 = moderate to severe dysfunction

Score: 10 or less = severe dysfunction

It is important to consider that GCS is only used for adult patients, as there are other validated rating scales for newborns and paediatrics. As GCS was developed to assess the conscious state of patients following traumatic brain injury, clinicians must use their clinical judgement in association with the GCS to assess conscious state. When communicating a patient's GCS to another healthcare professional it is important to convey the score of each response separately in addition to the total score. E.g. "the patient has a 2 for eyes opening, 2 for verbal response and 4 for motor response which is a total GCS of 8". Not all adult patients will normally function with a GCS of 15. For example, a patient who is intoxicated or suffers from dementia may have a transient or persistent GCS of 14, (eg 4,4,6 = 14).

Objective	Rationale	Action
Manage safety	Safety is the first priority in managing any patient.	1. Use universal precautions. Always wear gloves and goggles when attending to a patient. 2. You may also want to consider wearing a face mask and gown.
Assess eyes	A loud and clear vocal stimulus may be required to elicit a response. In some cases a pain stimulus may need to be applied over a longer period, sometimes up to 15 seconds. Always start with the least amount of pain necessary to elicit a response. Do not elicit a pain response by performing a knuckle rub on the patient's sternum as this can cause skin tearing. If a vocal or painful stimulus is applied and the patient opens their eyes, they attract the relevant score. If from then on their eyes remain open, they receive a 4. Remember: always give the best score possible.	Spontaneous (4): Observe the patient's eyes. A patient that has eyes that are opening spontaneously receives a 4. Voice (3): Supply vocal stimulus by asking the patient loudly and clearly to open their eyes. If the patient responds by opening their eyes they receive a 3. Pain (2): Elicit a pain response by pushing down behind the ear anterior to the mastoid process. You can also push down on the patient's finger nail bed. If the patient then opens their eyes they receive a score of 2.   None (1): If there is not any response to pain the patient receives a score of 1.

Objective	Rationale	Action
Assess verbal response	Although these are subjective observations try to ensure the best response is recorded. There are some patients, such as those with a speech impediment that may have difficulty demonstrating a GCS of 15. Therefore make sure this is recorded on any documentation and when handing the patient over to the receiving health worker. Other examples of people that may be unable to achieve a 5 for a verbal response are people under the influence of alcohol, edentulous or intellectually disabled people.	Orientated (5): Ascertain whether the patient is orientated to time and place. Patients' that respond appropriately receive a 5. Ask the patient questions which you know the answer to, such as; 'What day is it today'? and 'Do you know where you are at the moment?'. Confused (4): If the patient appears slightly confused and/or disorientated during conversation they receive a 4. Inappropriate speech (3): If the patient has random or muddled speech without exchange of information during conversation they receive a 3. Incomprehensible (2): If the patient is making sounds but is unable to formulate words they receive a 2. None (1): A patient that is unable to produce sounds receives a 1. This does not refer to aphasia due to any cause, such as airway obstruction or laryngeal injury.
Assess motor response	A patient that has impaired conscious state will score low in the motor response category. An example of a patient that may not receive a score of 6 is a patient that does not have full control over their limbs. Examples of this include, intoxicated patients, those with cerebral palsy, previous stroke, or other limb disability. Consider a normal person's reaction to a distal painful stimulus as opposed to a central painful stimulus when	Obeys Commands (6): A patient who responds to you and does what you ask receives a 6. In order to assess this, shake the persons hand upon arrival or ask them 'can I hold your wrist to take your pulse'? Localising to pain (5): Elicit a pain response through the techniques previously mentioned. If the patient purposefully attempts to remove the stimulus they receive a 5. E.g. the patient pushes your hand away if you elicit nail bed pressure. Withdraws to pain (4): Elicit a pain response through techniques previously mentioned. If the patient pulls away from the stimulus they receive a 4.

Objective	Rationale	Action
	eliciting a response. E.g. if you press on someone's nail bed, localising (5 points) may appear the same as withdrawing (4 points). Decorticate posturing can also be remembered by the position of someone that has 'caught-a-cat'. Alternatively you can remember that the limbs turn to the 'core'. DEcErEbratE can be remembered by the many E's in the word which you could take to mean extension of the limbs. It is possible for a person to exhibit decorticate posturing on one side of their body and decerebrate on the other.	<u>Abnormal Flexion (Decorticate)</u> (3): Elicit a pain response through techniques previously mentioned. If the patient's arms move toward their chest, their fingers and wrists flex on their chest and they point their toes, then they are said to have decorticate posturing and receive a 3. This posture is indicative of head injury and a patient may present in this position prior to any painful stimuli. <u>Abnormal Extension (Decerebrate)</u> (2): Elicit a pain response through techniques previously mentioned. If the patient's arms and legs extend, their wrists rotate away from their body and they point their toes, then they are said to have decerebrate posturing and receive a 2. This posture is also indicative of head injury and a patient may present in this position prior to any painful stimuli. <u>No Response</u> (1): A patient that does not have a motor response receives a 1.

DOCUMENTATION REQUIREMENTS GUIDANCE DIRECTIVE

Medicare and Medicaid will only provide reimbursement for ambulance transportation when the patient has a medical condition that makes the use of an ambulance medically necessary. For ambulance transportation to be considered medically necessary the patient's condition must be such that any other method of transportation would be contraindicated. **Therefore, your documentation must convey thoroughly and clearly the conditions which make ambulance transport medically necessary for the patient or that the patient could have been transported safely by some other means.**

The documentation requirements are the same in the past. This directive serves to identify how and where you need to document the medical necessity information. This will assist the Ambulance Claim Coders to readily "find" this information without having to "look" throughout the narrative.

When documenting the following transports, your narrative MUST CONTAIN and BEGIN with one of the identified selections below.

- Hospital to Nursing Home
- Hospital to Residence
- Nursing Home / Residence to Dialysis / Wound Care
- Dialysis / Wound Care to Nursing Home / Residence
- Nursing Home to Hospital (Priority 5 or when patient is in no acute distress)

Patient is bedconfined (unable to get up from bed without assistance, AND unable to ambulate, AND unable to sit in a chair or wheelchair

Narrative: Patient is bedconfined due to *(insert the current, observable signs/symptoms, OR conditions rendering the patient as being bedconfined).*

Patient requires stretcher transport (i.e., cannot safely be transported in a private auto or wheelchair van). Includes, but is not limited to such conditions as: Behavioral or cognitive risk such that patient requires monitoring for safety; Patient's physical condition is such that the patient risks injury during vehicle movement; Risk of falling off of wheelchair while in motion; Positioning in a wheelchair or standard seat of a car is inappropriate due to contractures, recent extremity fractures [post-op hip as an example], greater than grade 2 decubiti on buttocks, etc.).

Narrative: Patient requires ambulance stretcher transportation due to *(insert the current, observable signs/symptoms, OR conditions rendering the patient as requiring stretcher transport).*

Patient requires oxygen during transport – and is not prescribed as a self administered therapy

Narrative: Patient requires oxygen due to *(insert reason for need of oxygen)* and requires third party assistance.

Patient on a ventilator

Narrative: Patient requires advanced airway management due to being ventilator dependent.

Patient could clearly have safely been transported via wheelchair van or private auto

Narrative: Based on the observation and assessment of this patient, there are no findings which would contraindicate this patient from being transported in a wheelchair van or private auto.

When documenting Hospital to Hospital transports, your narrative MUST CONTAIN an identification of what services or treatments were not available at the hospital of origin.

FIELD GUIDANCE DIRECTIVE
DOCUMENTING HOSPITAL TO HOSPITAL TRANSPORTS

TO: All Field Personnel

FROM: Pafford Medical Billing Services Compliance Officer

RE: Documentation Requirements / Hospital-to-hospital Transports

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For hospital-to-hospital transports, the Narrative Section of the Patient Care Report must clearly indicate the precise treatment, procedure, or medical specialist that is available at the receiving hospital that was not available at the first.

Acceptable Examples:

"Transferred to XYZ Hospital:
- for evaluation by a heart surgeon not available at sending facility.
- for radiation therapy services needed and not available at sending facility.
- for rehabilitation services needed and not available at sending facility.
- for CT scan needed and not available to sending facility.
- because ICU was full at sending facility and no ICU beds were available.
- for abdominal surgery needed and not available at sending facility.
- for Trauma Services at a Level 1 Trauma Center not available at sending facility.

This is not an all-inclusive list and you must be very specific in your narrative documentation.

Non-specific or vague statements such as "needs cardiac care" or "needs higher level of care" are insufficient.

A NOTE OF CAUTION: The reason for the hospital to hospital transfer MUST BE DOCUMENTED IN THE NARRATIVE SECTION OF THE PCR. It is not acceptable to enter this information only in the Transport / Services Available – Explain data fields as this information is not printed on the hardcopy PCR.

➲Any hospital-to-hospital transport documentation which does not contain the precise treatment, procedure, or medical specialist for which the patient is being transport for and does not indicate if the services / specialist were or were not available at the sending facility *will be returned and you will be required to re-enter the call in its entirety*.

THIS DOCUMENT CONSTITUES A STATEMENT OF CORPORATE POLICY
FAILURE TO PROVIDE BY ITS PROVISIONS MAY RESULT IN DISCIPLINARY ACTION

Medicare, Medicaid, and other insurance companies generally cover ambulance transportation only to the nearest locality appropriate facility. Occasionally, the institution to which the patient is initially taken is found to have inadequate or unavailable facilities to provide the required care, and the patient is then transported to a second institution having appropriate facilities. In these cases, coverage is available only if the evidence clearly establishes that the destination institution was one with appropriate facilities under the particular circumstances. An "appropriate facility" is defined as a hospital that is generally equipped to provide the needed hospital care for the patient's injury or illness and it also means that a required physician or a physician specialist is currently available to provide the care required to treat the patient's condition. The fact that a more distant institution is better equipped, either qualitatively or quantitatively, to care for the patient does not warrant a finding that a closer institution does not have "appropriate facilities." Such a finding is warranted, however, if the beneficiary's condition requires a higher level of trauma care or other specialized service available only at the more distant hospital.

PAFFORD MEDICAL SERVICES

ALL TRANSPORTS FROM HOSPITAL TO HOSPITAL THE CREWS MUST FOLLOW THE 3 STEPS IN ENTERING THE PCR'S NO EXCEPTIONS.

1. The type of specialist or services the pt is transferring to.

2. Unavailable at the original facility. Or if the pt. requested the transfer.

3. The transferring diagnosis.

EX: PT TRANSFERRING TO SEE CARDIOLOGIST UNAVAILABLE AT XYZ HOSPITAL DUE TO CHEST PAIN ATRIAL FIB RVR.

Any hospital to hospital transport received without those 3 steps in the narrative are NOT BILLABLE and the PCR'S WILL BE RETURNED TO THE CREW MEMBER TO CORRECT.....

REMIND ALL THE CREWS TO FOLLOW THE 3 STEPS IN ENTERING THE HOSPITAL TO HOSPITAL DOCUMENTATION REQUIREMENTS.

PMBS GUIDANCE DIRECTIVE FOR FIELD PROVIDERS

- Incomplete Social Security Number listed on the hospital face sheets, example: 000-00-1234.
- No Social Security number listed on the hospital face sheet. Phantom numbers are not to be added, example: 999-99-9999
- In this case these should be left blank.

PAFFORD
MEDICAL SERVICES

STRETCHER NECESSITY

REQUIRED DOCUMENTATION

Example: " The patient requires ambulance transportation due to _____ "

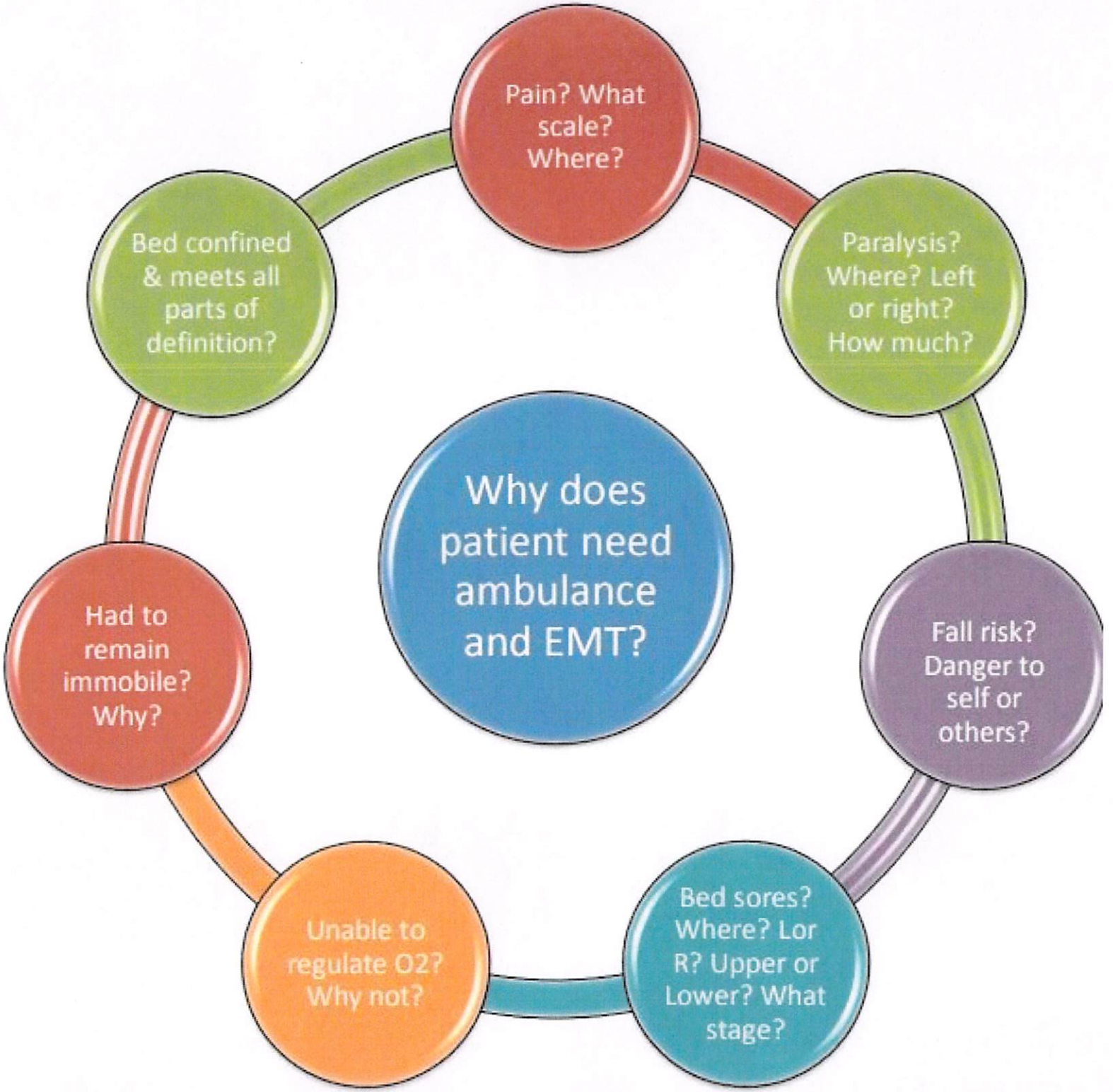
Your position as a healthcare professional is to clarify medical necessity and provide information to support the transportation.

Bedconfined Criteria

- Inability to ambulate
- Inability to sit in a chair or wheelchair
- Inability to get out bed without assistance

ALL 3 MUST BE MET TO BE CONSIDERED BEDCONFINED

CERTIFIED MEDICAL NECESSITY FORM MUST BE COMPLETED BY FACILITY NOT BY CREW.


Why does patient need ambulance and EMT?
Pain? What scale? Where?
Paralysis? Where? Left or right? How much?
Fall risk? Danger to self or others?
Bed sores? Where? Lor R? Upper or Lower? What stage?
Unable to regulate O2? Why not?
Had to remain immobile? Why?
Bed confined & meets all parts of definition?

Sample Ambulance Service Patient Mobility Report (PMR) – Version 1.1

Patient Name: _____ Date of Service: _____

Patient/Caregiver Reports

Mobility and Endurance

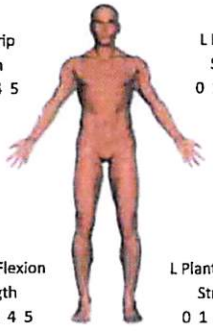
Reported By:		Pt Ability:
Pt	Caregiver	
☐	☐	Can ambulate *without* assistance
☐	☐	Can ambulate with assistance of cane or walker
☐	☐	Can ambulate for short distances only
☐	☐	Can stand and pivot but cannot ambulate
☐	☐	Unable to ambulate
☐	☐	Non-weight bearing on lower extremeties
☐	☐	Able to sit in a wheelchair for duration of transport
☐	☐	Able to sit in a chair or wheelchair, but cannot safely support self during transport
☐	☐	Unable to sit in a chair or wheelchair for any length of time
☐	☐	Has a pressure-sensitive dorsal wound
☐	☐	Is on fall precautions
☐	☐	Is on hip precautions
☐	☐	Is able to get out of bed without assistance
☐	☐	Cannot get out of bed without assistance

Glasgow Coma Scale (GCS)

Eye Opening Response	
Eyes open spontaneously	4
Eyes open in response to voice	3
Eyes open in response to pain	2
Does not open eyes	1
Verbal Response	
Oriented	5
Confused but able to answer	4
Inappropriate speech	3
Incomprehensible sounds	2
Makes no sounds	1
Motor Response	
Obeys commands	6
Movement to painful stimuli	5
Withdraws from pain	4
Flexion in response to pain	3
Extension in response to pain	2
No response	1
TOTAL GCS	____

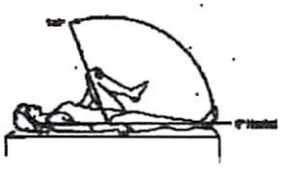
Tests

Strength

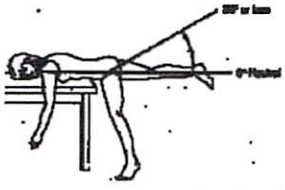


Range of Motion*

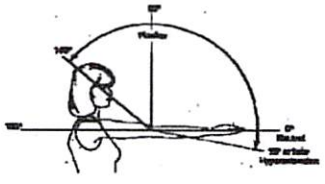
*Do not perform actual tests if doing so would endanger pt's health – use estimates instead



R Hip Max. Flexion 0° 30° 60° 90°+
L Hip Max. Flexion 0° 30° 60° 90°+



R Hip Max. Hyperextension 0° 15° 30°
L Hip Max. Hyperextension 0° 15° 30°



R Elbow Max. Flexion 0° 30° 60° 90° 120°+
L Elbow Max. Flexion 0° 30° 60° 90° 120°+

R Knee Max. Flexion 0° 45° 90° 120° 150°+
L Knee Max. Flexion 0° 45° 90° 120° 150°+

Ambulance Crew Observations

Position and Movement

- Observed pt ambulate *without* assistance
- Observed pt ambulate *with* cane, walker or other assistance
- Observed pt stand & pivot *without* assistance
- Observed pt stand & pivot *with* assistance
- Observed pt seated in a chair or wheelchair
- Observed pt recumbent in recliner/geri-chair
- Found pt in bed and remained supine throughout transport
- Observed pt get out of bed without assistance
- Observed pt get out of bed with assistance

Wounds/Appliances Observed by EMS Crew

Amputation		
Above knee	Left	Right
Below knee	Left	Right
Hand/arm	Left	Right
Foot/partial foot	Left	Right
Bandages		
Buttocks	Left	Right
Hip	Left	Right
Leg	Left	Right
Foot	Left	Right
Bruises		
Buttocks	Left	Right
Hip	Left	Right
Leg	Left	Right
Foot	Left	Right
Cast/Immobilizer/Splint		
Leg	Left	Right
Arm	Left	Right
Contractures		
Arm	Left	Right
Leg	Left	Right
Deformity/Swelling/Edema		
Buttock	Left	Right
Hip	Left	Right
Leg	Left	Right
Foot	Left	Right
Ulcers		
Buttocks	Left	Right
Hip	Left	Right
Leg	Left	Right
Foot	Left	Right
Back	Left	Right

Crew Signature

_____

Signature Date

_____

Print Name

EMPLOYEE ACKNOWLEDGEMENT
DOCUMENTING HOSPITAL TO HOSPITAL TRANSPORTS

I acknowledge that I have received, read, and understand the Field Guidance Directive regarding Documenting Hospital to Hospital Transports as issued.

I acknowledge and understand when documenting a hospital to hospital transport, the Narrative Section of the Patient Care Report must clearly indicate the precise treatment, procedure, or medical specialist the patient is being transported for and whether or not such treatment, procedure, or medical specialist is or is not available at the sending facility.

_____
Employee Signature

_____
Employee Name

_____
Date


Louisiana

Incorrect

Unisys 105 Attachment
Revised September, 2003

CERTIFICATION OF AMBULANCE TRANSPORTATION

Recipient Name Blake Taylor	Origin of Services nlmc
ID # of Recipient	Destination Ruston nH
Date of transport 01-01-18	Destination (address)

SECTION I (To Be Completed by MD/PA/NP/CNS/RN/DON)

Patient requires the level of medical transportation noted below:

Check One

	Emergency Ambulance: Patient's medical condition requires immediate transport and may require medical treatment en route. ***Describe the medical condition of the patient which requires this type of transport:***
✓	**Non-Emergency Ambulance**: The patient is bed-confined, i.e. unable to get up from bed without assistance, unable to ambulate; and unable to sit in a chair or wheelchair, and requires non-emergency ambulance transport, either scheduled or unscheduled, or the patient may require some simple medical care en route, but is stable, and is not likely to require the attendance of an EMT ***Describe the medical condition of the patient which requires this type of transport:***
	Non-Emergency Ambulance Patient will require transportation ___ (number) times a week during the month's ___, ___ (months) (year) to receive (dialysis, radiology, physical therapy). (Dialysis can be authorized for 2 consecutive months)
	Non-Ambulance, Non-Emergency: Patient is stable, not expected to require any medical attention en route, is ambulatory or wheel chair-bound, and can be transported in an automobile or van.

Patient transported to the above named facility for the following reason:

Check One

	Nearest Facility
	Preference of Physician
	The patient needs services available there.
	Other ***(describe):***

SECTION II (To Be Completed by Treating MD/PA/NP/CNS/RN/DON)

Note to Medical Professional: Signing this certification indicates that, in your professional judgment, transportation of the above named patient was necessary based on the patient's condition and in accordance with the statements in Section #1 above Payment and satisfaction of this claim will be from federal and state funds; any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal or state laws

I have read the above certification and I have read and understand the instructions on the reverse side of this form	
	I **agree** with the determination.
	I **disagree** with the determination, for the following reason's:

X Betty Boop, LPN — **Signature of MD/PA/NP/CNS/RN/DON**

Betty Boop — **Printed Name**

1-1-18 — **Date**

SECTION III To Be Completed by Ambulance Driver(s)

Signature of EMT or Paramedic	Printed Name	National EMT #	Date

Signature of EMT or Paramedic	Printed Name	National EMT #	Date

Note to Ambulance Provider: This form is a required attachment to the ambulance claim form Providers are not permitted to bill for services rendered to any Medicaid recipient unless this form is attached to the Unisys Form 105 Providers who bill electronically must retain this form on file in their offices for 5 years from the date of services If the patient is determined not to require ambulance transportation, the reimbursement rate will not exceed the non-ambulance, non-emergency rate

correct

Unisys 105 Attachment
Revised September, 2003

CERTIFICATION OF AMBULANCE TRANSPORTATION

Recipient Name Josh Whisenhunt	Origin of Services Springhill Medical Center
ID # of Recipient	Destination University
Date of transport 3-16-18	Destination (address)

SECTION I (To Be Completed by MD/PA/NP/CNS/RN/DON)

Patient requires the level of medical transportation noted below:

Check One

	Emergency Ambulance: Patient's medical condition requires immediate transport and may require medical treatment en route. ***Describe the medical condition of the patient which requires this type of transport:***
✓	**Non-Emergency Ambulance**: The patient is bed-confined, i.e. unable to get up from bed without assistance, unable to ambulate; and unable to sit in a chair or wheelchair, and requires non-emergency ambulance transport, either scheduled or unscheduled, or the patient may require some simple medical care en route, but is stable, and is not likely to require the attendance of an EMT ***Describe the medical condition of the patient which requires this type of transport:*** hip fx
	Non-Emergency Ambulance Patient will require transportation ___ (number) times a week during the month's ___ (months), ___ (year) to receive (dialysis, radiology, physical therapy). (Dialysis can be authorized for 2 consecutive months)
	Non-Ambulance, Non-Emergency: Patient is stable, not expected to require any medical attention en route, is ambulatory or wheel chair-bound, and can be transported in an automobile or van.

Patient transported to the above named facility for the following reason:

Check One

	Nearest Facility
	Preference of Physician
	The patient needs services available there.
✓	Other ***(describe):*** ortho

SECTION II (To Be Completed by Treating MD/PA/NP/CNS/RN/DON)

Note to Medical Professional: Signing this certification indicates that, in your professional judgment, transportation of the above named patient was necessary based on the patient's condition and in accordance with the statements in Section #1 above Payment and satisfaction of this claim will be from federal and state funds; any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal or state laws

I have read the above certification and I have read and understand the instructions on the reverse side of this form	
	I agree with the determination.
	I disagree with the determination, for the following reason's:

X Courtney Helms — **Signature of MD/PA/NP/CNS/RN/DON**

Courtney Helms, MD — **Printed Name**

3-16-18 — **Date**

SECTION III To Be Completed by Ambulance Driver(s)

Signature of EMT or Paramedic	Printed Name	National EMT #	Date

Signature of EMT or Paramedic	Printed Name	National EMT #	Date

Note to Ambulance Provider: This form is a required attachment to the ambulance claim form Providers are not permitted to bill for services rendered to any Medicaid recipient unless this form is attached to the Unisys Form 105 Providers who bill electronically must retain this form on file in their offices for 5 years from the date of services If the patient is determined not to require ambulance transportation, the reimbursement rate will not exceed the non-ambulance, non-emergency rate

Incorrect

Unisys 105 Attachment
Revised September, 2003

CERTIFICATION OF AMBULANCE TRANSPORTATION

Recipient Name Josh Whisenhunt	Origin of Services Springhill Medical Center
ID # of Recipient	Destination University
Date of transport 3-14-18	Destination (address)

SECTION I (To Be Completed by MD/PA/NP/CNS/RN/DON)

Patient requires the level of medical transportation noted below:

Check One

	Emergency Ambulance: Patient's medical condition requires immediate transport and may require medical treatment en route. ***Describe the medical condition of the patient which requires this type of transport:***
✓	**Non-Emergency Ambulance**: The patient is bed-confined, i.e. unable to get up from bed without assistance, unable to ambulate; and unable to sit in a chair or wheelchair, and requires non-emergency ambulance transport, either scheduled or unscheduled, or the patient may require some simple medical care en route, but is stable, and is not likely to require the attendance of an EMT ***Describe the medical condition of the patient which requires this type of transport:***
	Non-Emergency Ambulance Patient will require transportation ___ (number) times a week during the month's ___ (months), ___ (year) to receive (dialysis, radiology, physical therapy). (Dialysis can be authorized for 2 consecutive months)
	Non-Ambulance, Non-Emergency: Patient is stable, not expected to require any medical attention en route, is ambulatory or wheel chair-bound, and can be transported in an automobile or van.

Patient transported to the above named facility for the following reason:

Check One

	Nearest Facility
	Preference of Physician
	The patient needs services available there.
	Other ***(describe):***

SECTION II (To Be Completed by Treating MD/PA/NP/CNS/RN/DON)

Note to Medical Professional: Signing this certification indicates that, in your professional judgment, transportation of the above named patient was necessary based on the patient's condition and in accordance with the statements in Section #1 above Payment and satisfaction of this claim will be from federal and state funds; any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal or state laws

I have read the above certification and I have read and understand the instructions on the reverse side of this form	
	I **agree** with the determination.
	I **disagree** with the determination, for the following reason's:

X Courtney Helms — **Signature of MD/PA/NP/CNS/RN/DON**

Courtney Helms — **Printed Name**

3-16-18 — **Date**

SECTION III To Be Completed by Ambulance Driver(s)

Signature of EMT or Paramedic	Printed Name	National EMT #	Date
Signature of EMT or Paramedic	Printed Name	National EMT #	Date

Note to Ambulance Provider: This form is a required attachment to the ambulance claim form Providers are not permitted to bill for services rendered to any Medicaid recipient unless this form is attached to the Unisys Form 105 Providers who bill electronically must retain this form on file in their offices for 5 years from the date of services If the patient is determined not to require ambulance transportation, the reimbursement rate will not exceed the non-ambulance, non-emergency rate

Incorrect.

Unisys 105 Attachment
Revised September, 2003

CERTIFICATION OF AMBULANCE TRANSPORTATION

Recipient Name Kathy Heard	Origin of Services CMMC
ID # of Recipient	Destination Claiborne Manor
Date of transport 3-1-18	Destination (address)

SECTION I (To Be Completed by MD/PA/NP/CNS/RN/DON)

Patient requires the level of medical transportation noted below:

Check One

	Emergency Ambulance: Patient's medical condition requires immediate transport and may require medical treatment en route. ***Describe the medical condition of the patient which requires this type of transport:***
	Non-Emergency Ambulance: The patient is bed-confined, i.e. unable to get up from bed without assistance, unable to ambulate; and unable to sit in a chair or wheelchair, and requires non-emergency ambulance transport, either scheduled or unscheduled, or the patient may require some simple medical care en route, but is stable, and is not likely to require the attendance of an EMT ***Describe the medical condition of the patient which requires this type of transport:***
	Non-Emergency Ambulance Patient will require transportation ___ (number) times a week during the month's ___ (months), ___ (year) to receive (dialysis, radiology, physical therapy). (Dialysis can be authorized for 2 consecutive months)
	Non-Ambulance, Non-Emergency: Patient is stable, not expected to require any medical attention en route, is ambulatory or wheel chair-bound, and can be transported in an automobile or van.

Patient transported to the above named facility for the following reason:

Check One

	Nearest Facility
	Preference of Physician
	The patient needs services available there.
	Other ***(describe):***

SECTION II (To Be Completed by Treating MD/PA/NP/CNS/RN/DON)

Note to Medical Professional: Signing this certification indicates that, in your professional judgment, transportation of the above named patient was necessary based on the patient's condition and in accordance with the statements in Section #1 above Payment and satisfaction of this claim will be from federal and state funds; any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal or state laws

I have read the above certification and I have read and understand the instructions on the reverse side of this form	
	I **agree** with the determination.
	I **disagree** with the determination, for the following reason's:

X _____ **Signature of MD/PA/NP/CNS/RN/DON** _____ **Printed Name** _____ **Date**

SECTION III To Be Completed by Ambulance Driver(s)

Signature of EMT or Paramedic	Printed Name	National EMT #	Date
Signature of EMT or Paramedic	Printed Name	National EMT #	Date

Note to Ambulance Provider: This form is a required attachment to the ambulance claim form Providers are not permitted to bill for services rendered to any Medicaid recipient unless this form is attached to the Unisys Form 105 Providers who bill electronically must retain this form on file in their offices for 5 years from the date of services If the patient is determined not to require ambulance transportation, the reimbursement rate will not exceed the non-ambulance, non-emergency rate

correct

Unisys 105 Attachment
Revised September, 2003

CERTIFICATION OF AMBULANCE TRANSPORTATION

Recipient Name Kathy Heard	Origin of Services CMMC
ID # of Recipient	Destination Claiborne Manor
Date of transport 3-1-18	Destination (address)

SECTION I (To Be Completed by MD/PA/NP/CNS/RN/DON)

Patient requires the level of medical transportation noted below:

Check One

	Emergency Ambulance: Patient's medical condition requires immediate transport and may require medical treatment en route. ***Describe the medical condition of the patient which requires this type of transport:***
	Non-Emergency Ambulance: The patient is bed-confined, i.e. unable to get up from bed without assistance, unable to ambulate; and unable to sit in a chair or wheelchair, and requires non-emergency ambulance transport, either scheduled or unscheduled, or the patient may require some simple medical care en route, but is stable, and is not likely to require the attendance of an EMT ***Describe the medical condition of the patient which requires this type of transport:*** Paraplegia. contractures upper & lower ext
	Non-Emergency Ambulance Patient will require transportation ___ (number) times a week during the month's ___ (months), ___ (year) to receive (dialysis, radiology, physical therapy). (Dialysis can be authorized for 2 consecutive months)
	Non-Ambulance, Non-Emergency: Patient is stable, not expected to require any medical attention en route, is ambulatory or wheel chair-bound, and can be transported in an automobile or van.

Patient transported to the above named facility for the following reason:

Check One

	Nearest Facility
	Preference of Physician
	The patient needs services available there.
	Other ***(describe):***

SECTION II (To Be Completed by Treating MD/PA/NP/CNS/RN/DON)

Note to Medical Professional: Signing this certification indicates that, in your professional judgment, transportation of the above named patient was necessary based on the patient's condition and in accordance with the statements in Section #1 above Payment and satisfaction of this claim will be from federal and state funds; any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal or state laws

I have read the above certification and I have read and understand the instructions on the reverse side of this form	
	I agree with the determination.
	I disagree with the determination, for the following reason's:

X Betty Boop. LPN — Signature of MD/PA/NP/CNS/RN/DON

Betty Boop. LPN — Printed Name Discharge Planner

3-1-18 — Date

SECTION III To Be Completed by Ambulance Driver(s)

Signature of EMT or Paramedic	Printed Name	National EMT #	Date
Signature of EMT or Paramedic	Printed Name	National EMT #	Date

Note to Ambulance Provider: This form is a required attachment to the ambulance claim form Providers are not permitted to bill for services rendered to any Medicaid recipient unless this form is attached to the Unisys Form 105 Providers who bill electronically must retain this form on file in their offices for 5 years from the date of services If the patient is determined not to require ambulance transportation, the reimbursement rate will not exceed the non-ambulance, non-emergency rate

Correct

Unisys 105 Attachment
Revised September, 2003

CERTIFICATION OF AMBULANCE TRANSPORTATION

Recipient Name John Patford	Origin of Services NUMC
ID # of Recipient	Destination University
Date of transport 2-2-18	Destination (address)

SECTION I (To Be Completed by MD/PA/NP/CNS/RN/DON)

Patient requires the level of medical transportation noted below:

Check One

	Emergency Ambulance: Patient's medical condition requires immediate transport and may require medical treatment en route. ***Describe the medical condition of the patient which requires this type of transport:***
✓	**Non-Emergency Ambulance**: The patient is bed-confined, i.e. unable to get up from bed without assistance, unable to ambulate; and unable to sit in a chair or wheelchair, and requires non-emergency ambulance transport, either scheduled or unscheduled, or the patient may require some simple medical care en route, but is stable, and is not likely to require the attendance of an EMT · ***Describe the medical condition of the patient which requires this type of transport:*** Chest Pains, IV, EKG.
	Non-Emergency Ambulance Patient will require transportation ___ (number) times a week during the month's ___ (month(s)), ___ (year) to receive (dialysis, radiology, physical therapy). (Dialysis can be authorized for 2 consecutive months)
	Non-Ambulance, Non-Emergency: Patient is stable, not expected to require any medical attention en route, is ambulatory or wheel chair-bound, and can be transported in an automobile or van.

Patient transported to the above named facility for the following reason:

Check One

	Nearest Facility
	Preference of Physician
	The patient needs services available there.
✓	Other ***(describe):*** Cardiologist

SECTION II (To Be Completed by Treating MD/PA/NP/CNS/RN/DON)

Note to Medical Professional: Signing this certification indicates that, in your professional judgment, transportation of the above named patient was necessary based on the patient's condition and in accordance with the statements in Section #1 above Payment and satisfaction of this claim will be from federal and state funds; any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal or state laws

I have read the above certification and I have read and understand the instructions on the reverse side of this form	
	I **agree** with the determination.
	I **disagree** with the determination, for the following reason's:

X Betty Boop, RN — **Signature of MD/PA/NP/CNS/RN/DON**

Betty Boop, RN — **Printed Name**

02-02-18 — **Date**

SECTION III To Be Completed by Ambulance Driver(s)

Signature of EMT or Paramedic	Printed Name	National EMT #	Date

Signature of EMT or Paramedic	Printed Name	National EMT #	Date

Note to Ambulance Provider: This form is a required attachment to the ambulance claim form Providers are not permitted to bill for services rendered to any Medicaid recipient unless this form is attached to the Unisys Form 105 Providers who bill electronically must retain this form on file in their offices for 5 years from the date of services If the patient is determined not to require ambulance transportation, the reimbursement rate will not exceed the non-ambulance, non-emergency rate

Correct

Unisys 105 Attachment
Revised September, 2003

CERTIFICATION OF AMBULANCE TRANSPORTATION

Recipient Name Tracy Wold	Origin of Services NUMC
ID # of Recipient	Destination Ruston NH
Date of transport 01-01-18	Destination (address)

SECTION I (To Be Completed by MD/PA/NP/CNS/RN/DON)

Patient requires the level of medical transportation noted below:

Check One

	Emergency Ambulance: Patient's medical condition requires immediate transport and may require medical treatment en route. ***Describe the medical condition of the patient which requires this type of transport:***
✓	**Non-Emergency Ambulance**: The patient is bed-confined, i.e. unable to get up from bed without assistance, unable to ambulate; and unable to sit in a chair or wheelchair, and requires non-emergency ambulance transport, either scheduled or unscheduled, or the patient may require some simple medical care en route, but is stable, and is not likely to require the attendance of an EMT ***Describe the medical condition of the patient which requires this type of transport:*** Contractures. CVA. Bedconfined
	Non-Emergency Ambulance Patient will require transportation ___ (number) times a week during the month's ___ (months), ___ (year) to receive (dialysis, radiology, physical therapy). (Dialysis can be authorized for 2 consecutive months)
	Non-Ambulance, Non-Emergency: Patient is stable, not expected to require any medical attention en route, is ambulatory or wheel chair-bound, and can be transported in an automobile or van.

Patient transported to the above named facility for the following reason:

Check One

	Nearest Facility
	Preference of Physician
	The patient needs services available there.
	Other ***(describe):***

SECTION II (To Be Completed by Treating MD/PA/NP/CNS/RN/DON)

Note to Medical Professional: Signing this certification indicates that, in your professional judgment, transportation of the above named patient was necessary based on the patient's condition and in accordance with the statements in Section #1 above Payment and satisfaction of this claim will be from federal and state funds; any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal or state laws

I have read the above certification and I have read and understand the instructions on the reverse side of this form	
	I agree with the determination.
	I disagree with the determination, for the following reason's:

X Betty Boop. RN — **Signature of MD/PA/NP/CNS/RN/DON**

Betty Boop. RN — **Printed Name**

01-01-18 — **Date**

SECTION III To Be Completed by Ambulance Driver(s)

Signature of EMT or Paramedic	Printed Name	National EMT #	Date

Signature of EMT or Paramedic	Printed Name	National EMT #	Date

Note to Ambulance Provider: This form is a required attachment to the ambulance claim form Providers are not permitted to bill for services rendered to any Medicaid recipient unless this form is attached to the Unisys Form 105 Providers who bill electronically must retain this form on file in their offices for 5 years from the date of services If the patient is determined not to require ambulance transportation, the reimbursement rate will not exceed the non-ambulance, non-emergency rate


Mississippi

Invalid

CERTIFICATE OF MEDICAL NECESSITY
FOR NON-EMERGENCY AMBULANCE TRANSPORTATION
MEDICARE AND MISSISSIPPI MEDICAID

INSTRUCTIONS: This form provides the information needed to make medical necessity determinations for non-emergency ambulance transports on **MEDICARE** and **MEDICAID** CLAIMS.

PRINT NAME: First Clay Middle _____ Last Hobbs

Medicare # _____ **Medicaid #** _____ Other Insurance # _____

Transport From Hospital 123 To Hospital XYZ

Origin of Pick-up _____ Zip Code _____

Date(s) of Transport begin: _____ /End: _____ Frequency (repetitive trips) _____

If this is an interfacility transfer for upgrade in care, please document the receiving physician's specialty or facility specialty service, which the patient requires that the sending facility could not provide.

Reason for transport to this destination _____

Is this the closest appropriate facility that can provide this service? ☐Yes ☐ No → Explain _____

Diagnosis(es): 1) _____ 2) _____

This is a ☐new ☐ continued certification for this destination.

Ambulance transport is ☐ scheduled (scheduled ≥ 24 hrs. in advance) ☐ unscheduled (scheduled < 24 hrs. in advance)

Ambulance transportation is medically necessary for the following reasons

☐ **A. PATIENT IS BED CONFINED** Other means of transportation would be presumed to be contraindicated. Defined as (1) the inability to get up from bed without assistance, (2) inability to ambulate, and (3) inability to sit in a chair, including a wheelchair. This term is used synonymously with the terms "bedridden" or "stretcher bound". However, it is not synonymous with "bed rest" or "non-ambulatory".

All three of the above conditions must be met and will be applied to all transports.

Describe physical examination findings (not diagnoses) which necessitate the transport by ambulance:

1. Document why the patient cannot get up from bed without assistance.

2. Document why the patient cannot ambulate

3. Document why the patient cannot sit in a chair, including a wheelchair

☐ **B. OTHER MEANS OF TRANSPORTATION ARE CONTRAINDICATED** because it would be harmful to the patient's condition. Even if no other means of transportation are available, ambulance trips must be medically necessary and not for convenience. **FOR MEDICARE ONLY - significant medical documentation MUST accompany these claims.** Document why other means of transportation are contraindicated.

FOR MEDICARE BENEFICIARY

Designated medical personnel who falsely attest to a prescribed ambulance trip, "who knowingly or willfully makes or causes to be made any false statement or representation of a material fact in any application for **MEDICARE** benefits or payments under the applicable law, shall be guilty of a felony and conviction thereof resulting in a fine, imprisonment, or both."

FOR MEDICAID BENEFICIARY

A Physician, Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Registered Nurse or Discharge Planner who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for **MEDICAID** benefits or **MEDICAID** payments may be prosecuted under Federal and State criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the provider as a provider of **MEDICAID** services.

K. Doyle _____ K. Doyle _____ 02-01-05

Printed Name of MD, PA, NP, CNS, RN or D/C Planner | Signature of MD, PA, NP, CNS, RN or D/C Planner | Attestation Date

(Rev. 05/27/03)

Hosp- Hosp
Correct

CERTIFICATE OF MEDICAL NECESSITY
FOR NON-EMERGENCY AMBULANCE TRANSPORTATION
MEDICARE AND MISSISSIPPI MEDICAID

INSTRUCTIONS: This form provides the information needed to make medical necessity determinations for non-emergency ambulance transports on **MEDICARE** and **MEDICAID** CLAIMS.

PRINT NAME: First Clafton Middle _____ Last Hobbs

Medicare # 123-45-6789A **Medicaid #** 22222222 Other Insurance # 1111

Transport From Hospital ABC To Hospital 123

Origin of Pick-up _____ Zip Code _____

Date(s) of Transport begin: 02-01-15 /End: 02-01-15 Frequency (repetitive trips) _____

If this is an interfacility transfer for upgrade in care, please document the receiving physician's specialty or facility specialty service, which the patient requires that the sending facility could not provide.

Reason for transport to this destination Chest Pains

Is this the closest appropriate facility that can provide this service? ☑ Yes ☐ No → Explain Cardiology services

Diagnosis(es): 1) Chest Pains 2) Tachycardia

This is a ☐ new ☐ continued certification for this destination.

Ambulance transport is ☐ scheduled (scheduled ≥ 24 hrs. in advance) ☐ unscheduled (scheduled < 24 hrs. in advance)

Ambulance transportation is medically necessary for the following reasons

☑ **A. PATIENT IS BED CONFINED** Other means of transportation would be presumed to be contraindicated. Defined as (1) the inability to get up from bed without assistance, (2) inability to ambulate, and (3) inability to sit in a chair, including a wheelchair. This term is used synonymously with the terms "bedridden" or "stretcher bound". However, it is not synonymous with "bed rest" or "non-ambulatory".

All three of the above conditions must be met and will be applied to all transports.

Describe physical examination findings (not diagnoses) which necessitate the transport by ambulance:

1. Document why the patient cannot get up from bed without assistance.
   EKG. IV pump & Nitro.
2. Document why the patient cannot ambulate
   chest pains
3. Document why the patient cannot sit in a chair, including a wheelchair
   chest pains. EKG. IV

☑ **B. OTHER MEANS OF TRANSPORTATION ARE CONTRAINDICATED** because it would be harmful to the patient's condition. Even if no other means of transportation are available, ambulance trips must be medically necessary and not for convenience. **FOR MEDICARE ONLY - significant medical documentation MUST accompany these claims.** Document why other means of transportation are contraindicated. SAA

FOR MEDICARE BENEFICIARY

Designated medical personnel who falsely attest to a prescribed ambulance trip, "who knowingly or willfully makes or causes to be made any false statement or representation of a material fact in any application for **MEDICARE** benefits or payments under the applicable law, shall be guilty of a felony and conviction thereof resulting in a fine, imprisonment, or both."

FOR MEDICAID BENEFICIARY

A Physician, Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Registered Nurse or Discharge Planner who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for **MEDICAID** benefits or **MEDICAID** payments may be prosecuted under Federal and State criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the provider as a provider of **MEDICAID** services.

Printed name of MD, PA, NP, CNS, RN or D/C Planner — Signature of MD, PA, NP, CNS, RN or D/C Planner — 02-01-15

Printed Name of MD, PA, NP, CNS, RN or D/C Planner — Signature of MD, PA, NP, CNS, RN or D/C Planner — Attestation Date

(Rev. 05/27/03)

Hosp - NH
corrected

CERTIFICATE OF MEDICAL NECESSITY
FOR NON-EMERGENCY AMBULANCE TRANSPORTATION
MEDICARE AND MISSISSIPPI MEDICAID

INSTRUCTIONS: This form provides the information needed to make medical necessity determinations for non-emergency ambulance transports on **MEDICARE** and **MEDICAID** CLAIMS.

PRINT NAME: First Clayton Middle _____ Last Hobbs

Medicare # 123-45-6789A **Medicaid #** 22222222 Other Insurance # 1111

Transport From Hospital XYZ To Nursing Home ABC

Origin of Pick-up _____ Zip Code _____

Date(s) of Transport begin: 02-01-15 /End: 02-01-15 Frequency (repetitive trips) _____

If this is an interfacility transfer for upgrade in care, please document the receiving physician's specialty or facility specialty service, which the patient requires that the sending facility could not provide.

Reason for transport to this destination Contractures, AMS, bedconfined

Is this the closest appropriate facility that can provide this service? ☑ Yes ☐ No → Explain _____

Diagnosis(es): 1) Contractures 2) Bedconfined

This is a ☐ new ☐ continued certification for this destination.

Ambulance transport is ☐ scheduled (scheduled ≥ 24 hrs. in advance) ☐ unscheduled (scheduled < 24 hrs. in advance)

Ambulance transportation is medically necessary for the following reasons

☑ **A. PATIENT IS BED CONFINED** Other means of transportation would be presumed to be contraindicated. Defined as (1) the inability to get up from bed without assistance, (2) inability to ambulate, and (3) inability to sit in a chair, including a wheelchair. This term is used synonymously with the terms "bedridden" or "stretcher bound". However, it is not synonymous with "bed rest" or "non-ambulatory".

All three of the above conditions must be met and will be applied to all transports.

Describe physical examination findings (not diagnoses) which necessitate the transport by ambulance:

1. Document why the patient cannot get up from bed without assistance.
   Contractures, AMS, bedconfined
2. Document why the patient cannot ambulate
   Contractures, AMS, Bedconfined
3. Document why the patient cannot sit in a chair, including a wheelchair
   Contractures, Bedconfined

☑ **B. OTHER MEANS OF TRANSPORTATION ARE CONTRAINDICATED** because it would be harmful to the patient's condition. Even if no other means of transportation are available, ambulance trips must be medically necessary and not for convenience. **FOR MEDICARE ONLY - significant medical documentation MUST accompany these claims.** Document why other means of transportation are contraindicated. SHA

FOR MEDICARE BENEFICIARY

Designated medical personnel who falsely attest to a prescribed ambulance trip, "who knowingly or willfully makes or causes to be made any false statement or representation of a material fact in any application for **MEDICARE** benefits or payments under the applicable law, shall be guilty of a felony and conviction thereof resulting in a fine, imprisonment, or both."

FOR MEDICAID BENEFICIARY

A Physician, Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Registered Nurse or Discharge Planner who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for **MEDICAID** benefits or **MEDICAID** payments may be prosecuted under Federal and State criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the provider as a provider of **MEDICAID** services.

Josh Whisenhunt, RN — Josh Whisenhunt, RN — 02-01-15

Printed Name of MD, PA, NP, CNS, RN or D/C Planner | Signature of MD, PA, NP, CNS, RN or D/C Planner | Attestation Date

(Rev. 05/27/03)


ARKANSAS


Oklahoma

Incorrect

Pafford Emergency Medical Services

PHYSICIAN'S AUTHORIZATION FOR AMBULANCE SERVICE

Patient Josh Whisenhunt Date of Transport 01-01-2099

From Hospital A To Hospital B

To be covered ambulance services must be both **reasonable,** and **medically necessary.** Please fill out the following form.

PLEASE CHECK ANY OF THE FOLLOWING REASONS PERTAINING TO PATIENT'S CONDITION AT THE TIME OF TRANSPORT

_____ was bed confined - (for a beneficiary to be considered bed-confined, **ALL** of the following criteria must be met: a) The beneficiary is unable to get up from bed without assistance; b) The beneficiary is unable to ambulate; AND c) The beneficiary is unable to sit in a chair or wheelchair.) - **State reason confined (Be very specific)

_____

_____

_____ was transported in an emergency situation, e.g. as a result of an accident.

_____ needed to be restrained (chemically or otherwise)

_____ required Oxygen _____ EKG _____ IV

_____ had to remain immobile because of a fracture that had not been set or the possibility of a fracture.

_____ was experiencing a severe hemorrhage.

_____ could be moved by stretcher. **** State reason for stretcher transport, e.g. contractures, poss fx, decubitus, etc. ****

_____ Contractures	_____ Fetal	_____ Upper Extremities	_____ Lower Extremities
_____ Paralysis	_____ Quadriplegic	_____ Hemiparesis	_____ Semiparcsis
_____ Decubitus Ulcers	_____ Buttocks	_____ Coccyx	_____ Hip

_____ Staff - Other _____

_____

_____ Cardiac Reasons: ( ) A.L.S. Monitoring ( ) Dysrythmias ( ) Cardiac Cath ( ) CHF ( ) Pulmonary Edema
( ) Other - Explain: _____

STATE THE MEDICAL NECESSITY FOR TRANSFER OF THE PATIENT BY AMBULANCE, IF NOT CHECKED ABOVE:

_____

IF, INTER-HOSPITAL TRANSFER:

A: Type of Specialist Needed: _____

B: What Services were not available at first facility? _____

****** SIGNATURE and PRINTED NAME OF PHYSICIAN OR HEALTHCARE PROFESSIONAL REQUIRED******
IF PATIENT HAS MEDICAID, MUST BE SIGNED BY PHYSICIAN ONLY

Courtney Helm _____ 01-01-2099

PHYSICIAN'S SIGNATURE | PRINTED NAME and CREDENTIALS | DATE

For MEDICARE Patients, if unable to obtain attending physician's signature, any of the following may sign:

(Please check the appropriate box)

☐ Registered Nurse ☐ Discharge Planner ☐ Physician Assistant ☐ Nurse Practitioner ☐ Clinical Nurse Specialist

_____ _____ _____

NURSE'S/AUTHORIZED SIGNATURE | PRINTED NAME and CREDENTIALS | DATE

******IF NOT GIVEN TO THE AMBULANCE CREW, PLEASE FAX TO 1-800-464-1966 ******
IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT US AT : 1-800-451-8036

REV. 5/6/14

Incorrect

Pafford Emergency Medical Services

PHYSICIAN'S AUTHORIZATION FOR AMBULANCE SERVICE

Patient Josh Whisenhunt Date of Transport 01-01-2099

From _____ To _____

To be covered ambulance services must be both **reasonable,** and **medically necessary.** Please fill out the following form.

PLEASE CHECK ANY OF THE FOLLOWING REASONS PERTAINING TO PATIENT'S CONDITION AT THE TIME OF TRANSPORT

_____ was bed confined - (for a beneficiary to be considered bed-confined, **ALL** of the following criteria must be met: a) The beneficiary is unable to get up from bed without assistance; b) The beneficiary is unable to ambulate; AND c) The beneficiary is unable to sit in a chair or wheelchair.) - **State reason confined (Be very specific)

_____

_____

_____ was transported in an emergency situation, e.g. as a result of an accident.

_____ needed to be restrained (chemically or otherwise)

_____ required Oxygen _____ EKG _____ IV

_____ had to remain immobile because of a fracture that had not been set or the possibility of a fracture.

_____ was experiencing a severe hemorrhage.

_____ could be moved by stretcher. **** State reason for stretcher transport, e.g. contractures, poss fx, decubitus, etc. ****

_____ Contractures _____ Fetal _____ Upper Extremities _____ Lower Extremities
_____ Paralysis _____ Quadriplegic _____ Hemiparesis _____ Semiparcsis
_____ Decubitus Ulcers _____ Buttocks _____ Coccyx _____ Hip
_____ Staff - Other _____
_____

_____ Cardiac Reasons: ( ) A.L.S. Monitoring ( ) Dysrythmias ( ) Cardiac Cath ( ) CHF ( ) Pulmonary Edema
( ) Other - Explain: _____

STATE THE MEDICAL NECESSITY FOR TRANSFER OF THE PATIENT BY AMBULANCE, IF NOT CHECKED ABOVE:

_____

IF, INTER-HOSPITAL TRANSFER:

A: Type of Specialist Needed: _____

B: What Services were not available at first facility? _____

****** SIGNATURE and PRINTED NAME OF PHYSICIAN OR HEALTHCARE PROFESSIONAL REQUIRED******
IF PATIENT HAS MEDICAID, MUST BE SIGNED BY PHYSICIAN ONLY

_____ _____ _____
PHYSICIAN'S SIGNATURE PRINTED NAME and CREDENTIALS DATE

For MEDICARE Patients, if unable to obtain attending physician's signature, any of the following may sign:

(Please check the appropriate box)

☐ Registered Nurse ☐ Discharge Planner ☐ Physician Assistant ☐ Nurse Practitioner ☐ Clinical Nurse Specialist

_____ _____ _____
NURSE'S/AUTHORIZED SIGNATURE PRINTED NAME and CREDENTIALS DATE

******IF NOT GIVEN TO THE AMBULANCE CREW, PLEASE FAX TO 1-800-464-1966 ******
IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT US AT : 1-800-451-8036 REV. 5/6/14

Correct

Pafford Emergency Medical Services

PHYSICIAN'S AUTHORIZATION FOR AMBULANCE SERVICE

Patient Josh Whisenhunt Date of Transport 01-01-2099

From Hospital A To Hospital B

To be covered ambulance services must be both **reasonable,** and **medically necessary.** Please fill out the following form.

PLEASE CHECK ANY OF THE FOLLOWING REASONS PERTAINING TO PATIENT'S CONDITION AT THE TIME OF TRANSPORT

_____ was bed confined - (for a beneficiary to be considered bed-confined, **ALL** of the following criteria must be met: a) The beneficiary is unable to get up from bed without assistance; b) The beneficiary is unable to ambulate; AND c) The beneficiary is unable to sit in a chair or wheelchair.) - **State reason confined (Be very specific)

_____

_____

_____ was transported in an emergency situation, e.g. as a result of an accident.

✓ needed to be restrained (chemically or otherwise)

_____ required Oxygen _____ EKG _____ IV

_____ had to remain immobile because of a fracture that had not been set or the possibility of a fracture.

_____ was experiencing a severe hemorrhage.

_____ could be moved by stretcher. **** State reason for stretcher transport, e.g. contractures, poss fx, decubitus, etc. ****

_____ Contractures	_____ Fetal	_____ Upper Extremities	_____ Lower Extremities
_____ Paralysis	_____ Quadriplegic	_____ Hemiparesis	_____ Semiparcsis
_____ Decubitus Ulcers	_____ Buttocks	_____ Coccyx	_____ Hip

_____ Staff - Other _____

_____ Cardiac Reasons: ( ) A.L.S. Monitoring ( ) Dysrythmias ( ) Cardiac Cath ( ) CHF ( ) Pulmonary Edema
( ) Other - Explain: _____

STATE THE MEDICAL NECESSITY FOR TRANSFER OF THE PATIENT BY AMBULANCE, IF NOT CHECKED ABOVE:
Bipolar, agressive behavior, suicidal

IF, INTER-HOSPITAL TRANSFER:

A: Type of Specialist Needed: Psychiatric

B: What Services were not available at first facility? Psychiatric

****** SIGNATURE and PRINTED NAME OF PHYSICIAN OR HEALTHCARE PROFESSIONAL REQUIRED******
IF PATIENT HAS MEDICAID, MUST BE SIGNED BY PHYSICIAN ONLY

Courtney Helms	Courtney Helms, MD	01-01-2099
PHYSICIAN'S SIGNATURE	PRINTED NAME and CREDENTIALS	DATE

For MEDICARE Patients, if unable to obtain attending physician's signature, any of the following may sign:

(Please check the appropriate box)

☑ Registered Nurse ☐ Discharge Planner ☐ Physician Assistant ☐ Nurse Practitioner ☐ Clinical Nurse Specialist

Vickie Foster	Vickie Foster. RN	01-01-2099
NURSE'S/AUTHORIZED SIGNATURE	PRINTED NAME and CREDENTIALS	DATE

******IF NOT GIVEN TO THE AMBULANCE CREW, PLEASE FAX TO 1-800-464-1966 ******
IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT US AT : 1-800-451-8036

REV. 5/6/14

Correct

Pafford Emergency Medical Services

PHYSICIAN'S AUTHORIZATION FOR AMBULANCE SERVICE

Patient Josh Whisenhunt Date of Transport 01-01-2099

From Hospital XYZ To Hospital 123

To be covered ambulance services must be both **reasonable,** and **medically necessary.** Please fill out the following form.

PLEASE CHECK ANY OF THE FOLLOWING REASONS PERTAINING TO PATIENT'S CONDITION AT THE TIME OF TRANSPORT

_____ was bed confined - (for a beneficiary to be considered bed-confined, **ALL** of the following criteria must be met: a) The beneficiary is unable to get up from bed without assistance; b) The beneficiary is unable to ambulate; AND c) The beneficiary is unable to sit in a chair or wheelchair.) - **State reason confined (Be very specific)

_____

_____

_____ was transported in an emergency situation, e.g. as a result of an accident.

_____ needed to be restrained (chemically or otherwise)

✓ required Oxygen ✓ EKG ✓ IV

_____ had to remain immobile because of a fracture that had not been set or the possibility of a fracture.

_____ was experiencing a severe hemorrhage.

_____ could be moved by stretcher. **** State reason for stretcher transport, e.g. contractures, poss fx, decubitus, etc. ****

_____ Contractures _____ Fetal _____ Upper Extremities _____ Lower Extremities
_____ Paralysis _____ Quadriplegic _____ Hemiparesis _____ Semiparcsis
_____ Decubitus Ulcers _____ Buttocks _____ Coccyx _____ Hip
_____ Staff - Other _____

_____

✓ Cardiac Reasons: (✓) A.L.S. Monitoring ( ) Dysrythmias ( ) Cardiac Cath ( ) CHF ( ) Pulmonary Edema
( ) Other - Explain: _____

STATE THE MEDICAL NECESSITY FOR TRANSFER OF THE PATIENT BY AMBULANCE, IF NOT CHECKED ABOVE:

Chest pains, SOB.

IF, INTER-HOSPITAL TRANSFER:

A: Type of Specialist Needed: Cardiology

B: What Services were not available at first facility? cardiology

****** SIGNATURE and PRINTED NAME OF PHYSICIAN OR HEALTHCARE PROFESSIONAL REQUIRED******
IF PATIENT HAS MEDICAID, MUST BE SIGNED BY PHYSICIAN ONLY

PHYSICIAN'S SIGNATURE | PRINTED NAME and CREDENTIALS | DATE

For MEDICARE Patients, if unable to obtain attending physician's signature, any of the following may sign:

(Please check the appropriate box)

✓ ☐ Registered Nurse ☐ Discharge Planner ☐ Physician Assistant ☐ Nurse Practitioner ☐ Clinical Nurse Specialist

Nancy Noitall. RN | Nancy Noitall, RN | 01-01-2099

NURSE'S/AUTHORIZED SIGNATURE | PRINTED NAME and CREDENTIALS | DATE

******IF NOT GIVEN TO THE AMBULANCE CREW, PLEASE FAX TO 1-800-464-1966 ******
IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT US AT : 1-800-451-8036

REV. 5/6/14

Medicaid - OK
NH to H
NH to Dr. office
and return trip

Oklahoma HealthCare Authority

CERTIFICATE OF MEDICAL NECESSITY
Nursing Home Non-Emergency and Emergency Ambulance Transport

Date of Transport: _____

Patient Name: _____ Soonercare #_____

Origin: _____ Destination _____

* 1. What medical Condition exists that makes transport by ambulance necessary?

_____

_____

_____

* 2. Please check any or all of the following that apply.

____ This patient is unconscious and/or unresponsive to voice/pain.

____ This patient requires administration of medical care and/or assessment during transport. (Cardiac monitoring, Medication administration, O2, etc.)

____ This patient must be transported on a stretcher and may not be transported in a sitting position such as a wheelchair.
Please state why: _____

_____

____ This patient has a contagious disease. Please state DX._____

____ This patient requires restraint and/or constant attendance due to confusion or combativeness.

I certify to the best of my professional ability that this patient's condition warrants ambulance transportation and no lesser means is medically appropriate.

* Print Physician Name: _____

* Physician Signature: _____ Date: _____

RN, NP, DR can all sign

Caid-OK
H to H

Oklahoma Health Care Authority

Physician's Certification Statement

Patient:_____ Run#:_____

Medicare#:_____ Date of Service:_____

Origin:_____ Destination:_____

Level of Care Required:

1. Is the treatment for which the patient is being transferred available at the hospital of origin? Yes☐ No☐
2. If treatment is not available, what is the specific service(s) for which the patient is being transported?

Patient's Ambulatory Status:

1. Can the patient sit up in a chair? Yes☐ No☐
2. If patient can sit in chair, amount of time patient can tolerate sitting: _____
3. If patient is confined to bed, what movement limitations prevent the patient from getting out of bed (i.e. location of any paralysis; balance limitations; etc.)?

   _____
4. What illness created the movement limitations in #3?

   _____

Does the patient require O2 for this transport? Yes☐ No☐

1. For what condition is it required? _____

Other Conditions:

1. Other conditions affected by travel in such a way that without ambulance transportation, harm would come to the patient: _____

2. What harm might be expected? _____

Signature _____ Title_____ Date_____

ONLY A PHYSICIAN, RN, DISCHARGE PLANNER, PHYSICIAN ASSISTANT, NURSE PRACTIONER, OR CLINICAL NURSE SPECIALIST CAN SIGN THIS FORM

_____

Name Printed

TO BE COMPLETED BY AMBULANCE: MILES TRAVELED ONE WAY:

PLEASE COMPLETE AND SIGN THIS FORM AND GIVE TO TRANSPORTATION PROVIDER

- PCS coordinator needs to fill out
  Dr fills out

Caid – OK
Hospital to NH
Hospital to R

Oklahoma Health Care Authority

Physician's Certification Statement

Patient:_____ Run#:_____

Medicare#:_____ Date of Service:_____

Origin:_____ Destination:_____

Level of Care Required:

1. Is the treatment for which the patient is being transferred available at the hospital of origin? Yes☐ No☐
2. If treatment is not available, what is the specific service(s) for which the patient is being transported?

* **Patient's Ambulatory Status:**

1. Can the patient sit up in a chair? Yes☐ No☐
2. If patient can sit in chair, amount of time patient can tolerate sitting: _____
3. If patient is confined to bed, what movement limitations prevent the patient from getting out of bed (i.e. location of any paralysis; balance limitations; etc.)?

   _____
4. What illness created the movement limitations in #3?

   _____

   Does the patient require O2 for this transport? Yes☐ No☐

   1. For what condition is it required? _____

* **Other Conditions:**

1. Other conditions affected by travel in such a way that without ambulance transportation, harm would come to the patient: _____

2. What harm might be expected? _____

* Signature _____ Title_____ Date_____

ONLY A PHYSICIAN, RN, DISCHARGE PLANNER, PHYSICIAN ASSISTANT, NURSE PRACTIONER, OR CLINICAL NURSE SPECIALIST CAN SIGN THIS FORM

* _____

Name Printed

TO BE COMPLETED BY AMBULANCE: MILES TRAVELED ONE WAY:

PLEASE COMPLETE AND SIGN THIS FORM AND GIVE TO TRANSPORTATION PROVIDER

• PCS coordinator fills out

Dr fills out

DCHART

D-DISPATCH

C-CHIEF COMPLAINT

H-HISTORY OF PRESENT ILLNESS /

PERT PAST HISTORY

A-ASSESSMENT

R-TREATMENTS/MEDS/PROCEDURES

T-TRANSPORT

E- EXCEPTIONS- ANYTHING OF OTHER IMPORTANCE THAT NEEDS NOTED IN THE PCR

Abbreviations

Abbreviation	Meaning
a	Before
Aa	Of each
A&OX3	alert & oriented to person, place, and time
A&OX4	alert & oriented to person, place, time and situation
ABC	airway, breathing, circulation
abd	abdomen
Ab	abortion
ac	before meals
ACLS	advanced cardiac life support
admin	administration
A-fib	atrial fibrillation
A-flut	atrial flutter
ALS	advanced life support
AMA	against medical advice
AMI	acute myocardial infarction
AMPS	ampules
ant	anterior
AP	anteroposterior
ARDS	adult respiratory distress syndrome
ASA	aspirin
ASCVD	arteriosclerotic cardiovascular disease
ASHD	atherosclerotic heart disease
A-tach	atrial tachycardia
AV	atrioventricular
BBB	bundle branch block
BBS	bilateral breath sounds
bid	twice a day
BM	bowel movement
BP	blood pressure
BPM	beats per minute
BS	breath sounds
BSA	body surface area
BVM	bag-valve-mask
c	with
Ca	cancer
Ca++	calcium
CAB	coronary artery bypass
CACL	calcium chloride
CAD	coronary artery disease
Caps	capsule
Cath	catheter
CBC	complete blood count
CBG	capillary blood glucose
cc	cubic centimeter
CC	chief complaint
C/C	chief complaint
CCU	coronary care unit
CHF	congestive heart failure
Cl-	chloride
cm	centimeter
CNS	central nervous system
c/o	complains of
CO	carbon monoxide
COD	codeine
CO2	carbon dioxide
cont	continue
COPD	chronic obstructive pulmonary disease
CPR	cardiopulmonary resuscitation
CSF	cerebrospinal fluid
C-spine	cervical spine
C-section	cesarean section
CTA	clear to auscultation
CVP	central venous pressure
CXR	chest x-ray
D/C	hospital discharge

Abbreviation	Meaning
D & C	Dilatation and curettage
Detox	Detoxification
Dig	Digitalis
DM	diabetes mellitus
DNR	do not resuscitate
DOA	dead on arrival
DOE	dyspnea on exertion
DPT	diphtheria, pertussis, and tetanus vaccine
DT's	delirium tremens
D5W	dextrose 5% in water
D50W	dextrose 50% in water
Dx	Diagnosis
ECG	Electrocardiogram
EEG	Electroencephalogram
EENT	eye, ear, nose and throat
EMD	electromechanical dissociation
ENT	Ear, nose and throat
EOA	esophageal obturator airway
Epi	Epinephrine
ER/ED	emergency department
ET	Endotracheal
EtCO2	End tidal CO2
ETT	endotracheal tube
ETA	estimated time of arrival
ETOH	ethyl alcohol
Exam	Examination
F	Female
F	Fahrenheit
Fib	Fibrillation
Fl	Fluid
Ft	Foot
Fx	Fracture
G	Grams
GCS	Glasgow Coma Scale
GI	Gastrointestinal
Gr	Grain
GSW	gunshot wound
Gtts	Drops
GU	Genitourinary
GYN	Gynecologic
Hr	hour
Hgb	hemoglobin
Hct	hematocrit
HEENT	head, eyes, ears, nose & throat
Hg	mercury
H & P	history and physical
HPI	history of present illness/injury
Ht	height
Hx	history
H2O	water
ICP	intracranial pressure
ICU	intensive care unit
IDDM	Insulin dependent Diabetes Mellitus
I.e.	that is
IM	intramuscular
IO	intraosseous
IPPB	intermittent positive pressure breath
IVP	intravenous push
IVPB	IV piggy back
J	joules
JVD	jugular vein distention
K+	potassium
Kg	kilogram
KVO	keep vein open
Lt	Left

Abbreviations

Abbreviation	Meaning
temp	temperature
TIA	transient ischemia attack
tid	three times a day
TKO	to keep open
tsp	teaspoon
Tx	treatment
U	unit
URI	upper respiratory infection
UTD	unable to determine
UTI	urinary tract infection
VD	venereal disease
V-fib	ventricular fibrillation
via	by way of
vol	volume
VS	vital signs
V-tach	ventricular tachycardia
WBC	white blood count
wc	wheelchair
w/s	watt/second
wt	weight
y/o	year old
≈	APPROXIMATE
@	at

Abbreviation	Meaning
↑	increased, elevated
↓	decreased, depressed
=	equal
≠	not equal
→	going to or leading to
∅	none
μ	micro
X 2	times two
/	per; and or
>	greater than
<	less than
?	questionable
⊕	positive
-	negative
Δ	change
1°	primary, first degree
2°	secondary, second degree
∴	therefore

D- DISPATCHED PRIORITY 1 TO RESIDENCE IN ******* FOR STROKE/CARDIAC SYMPTOMS

C- PT COMPLAINS OF CRUSHING CHEST PAIN

+

O-- UPON WAKING

P-- NONE

Q-- CRUSHING

R-- LEFT ARM

S-- 9/10

T-- 0800

H- PT STATES UPON WAKING UP SHE WAS HAVING CRUSHING CHEST PAIN AND TOOK 324 ASA. PT CONTINUED EXPERIENCING CRUSHING CP THROUGHOUT THE DAY.

+

A-- PEN

M-- UNKNOWN

P-- UNKNOWN

L-- NIGHT PRIOR

E-- WAKING UP

A- UPON ARRIVAL TO RESIDENCE PT IS FOUND LAYING SUPINE IN BED WITH RAPID SHALLOW BREATHING, PALE SKIN COLOR, AND DIAPHORETIC. PT WAS A&Ox4 GCS 15. PT PLACED ON CARDIAC MONITOR AND VITAL SIGNS ACQUIRED. 12-LEAD ESTABLISHED AND PT GIVEN NITRO AND ASA. AND IV ESTABLISHED. HELICOPTER CONTACTED

R- ALS ASSESSMENT VITAL SIGNS CARDIAC MONITOR W/ 12-LEAD ESTABLISHED, ASA, EN ROUTE PT GIVEN MORPHINE AND NITRO.

T- PT MOVED TO COT BY SCOOTING FROM BED TO COT WITHOUT INCIDENT OR ASSISTANCE. PT MOVED TO AMBULANCE SECURED PER SAFTEY PROTOCOLS. PT TRANSPORTED CODE 3 FROM RESIDENCE TO LZ WITHOUT INCIDENT UPON ARRIVAL TO LZ PT CP DECREASED TO 4/10 FROM INITIAL 9/10. EN ROUTE TO CANADIAN LZ, CHANGED TO ARROWHEAD LZ. PT MOVED FROM GROUND CREW COT TO ROTARY WING COT AND PLACED IN HELICOPTER. PT CARE TRANSFERRED TO ROTARY WING CREW PARAMEDIC

D-UNIT 212 RESPONDED P4 TO HMH ER [redacted] FOR PT TRANSPORT TO [redacted] FOR POST CARDIAC ARREST

PT WILL REQUIRE STRETCHER AND ACLS PARAMEDIC AMBULANCE TRANSPORT / CM / ADVANCED AIRWAY MONITORING / VENTILATOR / IV MONITORING AND MAINTENANCE ENROUTE

C-PT IS UNRESPONSIVE GCS 3 POST CARDIAC ARREST SECONDARY TO VENTRICULAR FIBRILLATION AND RESPIRATION ARREST PT IS INTUBATED AND SEDATED

H-PT WAS BROUGHT IN TO ED APPX 2000 HOURS TODAY BY OTHER EMS COMPANY FROM HOME

FAMILY STATED PT HAD EATEN DINNER AND WAS READING A BOOK THEN WENT INTO SEIZURE LIKE ACTIVITY PT LOST CONSCIOUSNESS PT HAD NO PULSE FAMILY STARTED CPR AND CONTINUED UNTIL EMS ARRIVED TOOK OVER CPR ON SCENE AND TRANSPORTED PT TO HMH ED

PT LIST NO ALLERGIES AND NO OTHER MED HX IN CHART

A-U/A FOUND [redacted] Y/O [redacted] UNRESPONSIVE PT [redacted] GCS 3 CHEMICALLY SEDATED AND INTUBATED WITH 7.5 ET TUBE SECURED WITH TUBE HOLDER @ 24 ON THE LIPS PT IS ON VENTILATOR ASSIST CONTROL RATE OF 24 , TV = 500 , PEEP OF 7, FIO2 OF 100 % / SINUS TACH W/ MULTIFOCAL PVC's > 6 MIN ON CM 4 LEAD WITH ETCO2 SHOWING 38mmHg / IV PUMP W/ NS @ TKO / DIPRIVAN @ 6.6 mL PER Hr = 10 mcg/kg/Hr/ PT HAS IV SITE TO RIGHT A/C 20 GAGE WERE MEDICATIONS BEING ADMINISTERED PT HAS 20 GAGE TO LEFT HAND W/ LOCK IN PLACE PT HAS FOLLY CATH IN PLACE PT HAS NG TUBE IN PLACE CAPPED OFF AND NOT HOOKED UP TO SUCTION

PT AIRWAY / BREATHING CONTROLLED AND ASSISTED BY ET & VENT , PUPILS NON REACTIVE DILATED TO 6, NO JVD NO TRACH DEVIATION NOTED, PT ADB IS DISTENDED PT PULSES PRESENT IN ALL EXTREMITIES, PT HAS NO BLEEDING NOTED. PT SKIN PINK WARM AND DRY

PT BEING TRANSFERRED FOR POST CARDIAC ARREST /ACUTE RESPIRATORY FAILURE W/HYPOXEMIA & HYPERCAPNIA

PT ADMITTING DX OF CARDIAC ARREST 2ND TO VENTRICULAR FIBRILLATION / ASPIRATION PNEUMONIA W/ HYPOXEMIA AND RESPIRATORY FAILURE

PT NEEDS SPECIALITY SERVICES OF PULMONOLOGY / CARDIOLOGY / INTENSIVIST/ NOT AVB AT SENDING FACILITY

R-ALS ASSESSMENT, CM 4 LEAD , IV NS TK / IV ON PUMP W/ DIPRIVAN RUNNING @ 6.6 HAD TO CUT BACK TO 5 WHEN PT BP DROPPED / VENTILATOR / CAPNOGRAPHY /

T-PT LOADED ONTO COT BY STAFF AND EMS EMS CONFIRMED TUBE PLACEMENT ASCULTATION OF BREATH SOUNDS & ETCO2 PT SECURED PER SAFETY PROTOCOL IN SEMI-FOWLER POSITION PT EQUIPMENT ALL SECURED FOR TRANSPORT . PT TRANSPORTED CODE 3 TO CSMHC TK PT HAD SLIGHT CHANGE IN BLOOD PRESSURE DURING TRANSIT HAD TO ADJUST FLOW OF DIPRIVAN TO IMPROVE BP PT HAD NO OTHER NOTABLE CHANGES AFTER ADJUSTMENT OF MEDICATIONS . PT REP GIVEN TO CSMHC VIA RADIO APPX 5 MIN PTA

UA PT TAKEN TO [redacted] PT MOVED FROM COT TO BED BY EMS AND STAFF SECURING ALL LINES AND TUBES PT MOVED FROM EMS VENT TO HOSPITAL VENT BY HOSPITAL RESPIRATORY STAFF TUBE PLACEMENT CONFIRMED BY EMS AND HOSPITAL STAFF VIA ASCULTATION OF BI LAT BREATH SOUNDS AND ETCO2 AFTER PT TRANSFER FROM COT TO BED PT REPORT GIVEN TO STAFF CARE TRANSFER PAPERWORK AND BELONGING TURNED OVER TO STAFF

D -- DISPATCHED PRIORITY _ TO

RESPONDS TO

RESPONDS FROM

PEOPLE ON SCENE

ADDITIONAL RESOURCES DISPTACHED

CONDITON OF RESIDENCE

ENVIRONMENTAL FACTORS

DELAYS

EMS ENTERS THE SCENE TO FIND THE PATIENT

C -- CONSENTS TO TREATMENT, TRANSPORT, AND ASSESSMENT.

WHEN EMS WAS CALLED THE PATIENT WAS EXPERIENCING

PAIN SCALE

WHEN EMS ARRIVED THE PATIENT WAS EXPERIENCING

PAIN SCALE

WHAT WAS THE PATIENT DOING WHEN IT STARTED

WHEN DID IT START

TYPE OF PAIN

RADIATION OF PAIN

DOES ANYTHING MAKE IT BETTER/WORSE

EVER HAPPENED BEFORE

WHAT DID THEY DO FOR IT

H -- MEDICAL HISTORY

SURGICAL HISTORY

MEDICAL ALLERGIES

ENVIRONMENTAL ALLERGIES

REACTIONS TO ALLERGIES

RECEIVED INFORMATION FROM

PRESCRIBED MEDICATIONS TAKEN TODAY

OVER THE COUNTER MEDICATIONS TAKEN TODAY

PHYSICIAN CONTACTED

PCP

ANY RECENT ILLNESS OR HOSPITAL STAYS

HOME HEALTH/HOSPICE

WERE HH OR HOSPICE CONTACTED

SMOKING/DRINKING/DRUGS

A -- MENTAL STATUS

TYPICAL STATUS

GCS

E --

V --

M --

ABILITY TO FOLLOW COMMANDS

DEMEANOR

HARD OF HEARING

DOUBLE VISION OR BLURRED VISION

EYES

GLASSES/CONTACTS/GLAUCOMA/CATARACTS

SYNCOPE

DIZZINESS

RESPIRATORY RATE

QUALITY

DEPTH

ISSUES SPEAKING OR SWALLOWING

COUGH/MUCUS

JVD/TRACHEAL DEVIATION

SKIN TEMP

ENVIROMENTAL TEMP

TURGOR

CONDITION

MOISTURE

ABDOMINAL PAIN

ABDOMINAL TENDERNESS

ABDOMINAL DISTENTION

ABDOMINAL GUARDING

MENSTRUAL PERIOD

ERECTIAL DYSFUNCTION MEDICATIONS

BLOOD GLUCOSE LEVEL

TYMPANIC TEMP

CARDIAC RHYTHM

CARDIAC RATE

PACEMAKER/DEFIBRILLATOR

NAUSEA/VOMITING

CHEST PAIN

HIP PAIN

NECK/BACK PAIN

RECENT TRAUMA OR FALLS

EXTREMITIES

ASSISTANCE FOR WALKING

GAIT

WOUNDS

EDEMA

LABS/XRAY/CT READINGS

REASON FOR ADMISSION

EATING/DRINKING

PEEING/POOPING

ADDITIONAL EQUIPMENT / PICC /FOLEY / PEG

PERTINENT NEGATIVES

SCENE --

R -- TREATMENT PRIOR TO ARRIVAL

EMS TREATMENT

IV/LOCATION

FLUID RESUSCITATION

DRUGS/INTERACTIONS

NARCOTIC USED/SIGNED/WASTED

ORDERS/PROTOCOL FOR INTERVENTIONS

REPEAT ASSESSMENT

T -- PATIENT MOVED TO STRETCHER VIA

PATIENT SECURED VIA TOP HARNESS AND TWO STRAPS ACROSS LEGS AND TWO RAILS RAISED. PATIENT PLACED IN THE __ POSITION

THE POSITION IS NOTED AS COMFORT POSITION FOR THE PATIENT

BLANKETS/PILLOWS

STRETCHER LOCKED INTO PLACE BY LOCK BAR WITH ALL DOORS SECURE

TRANSPORTED CODE

DELAYS

DESTINATION

DESTINATION DECISION

RIDERS / FOLLOWING

PHONE REPORT GIVEN TO

ORAL REPORT GIVEN TO

BELONGINGS WITH PATIENT

PATIENT PLACED IN

PATIENT MOVED VIA

RAILS RAISED AND STAFF PRESENT

WE ARE CLEAR OF THE PATIENT AT THIS TIME

D- UNIT _____ RESPONDED PRIORITY _____ FOR _____ IN / AT _____

C- PT STATES THEY HAVE _____ OR PT C/O _____OR PT HAS INJURIES FROM _____ OF _____.

H- PT WAS _____ PRIOR TO CALLING FOR EMS TODAY_____.

PT HAS MED HX OF _____ PT HAS PAST SURGICAL HX OF _____.

PT HAS FOOD ALLERGIES & DRUG ALLERGIES OF _____

A-UPON ARRIVAL FOUND _____ Y/O M/F IN _____POSITION LOCATED _____.

A&OX'S ___, GSC ____, _____PUPILS, BREATH SOUNDS _____ & AT _____ RATE AND QUALITY, ___JVD, TRACHEA_____, ABD _____, BACK _____, CERVICAL, THORACIC, LUMBAR EXAM _____. SMC'S IN TACT X'S _____ W/_____DEFICIT NOTED, SKIN _____, _____ & _____,

---

PT HAS PAIN SCALE OF _____/10 AND DESCRIBES PAIN AS _____. PT D-STK/ CBG _____.

PT SHOWING _____ RHYTHM ON _____LEAD.

H2H 1. PT TRANSFERING DX _____

2. _____SERVICES ARE NOT AVB AT _____ /OR TRANSFER IS @ PT REQUEST

3. PT WILL BE RECEIVING _____SPECIALITY SERVICES AT _____

DISCHARGES- 1. PT REQUIRES EMS TRANSPORT DUE TO _____

2. PT IS UNABLE TO _____ SAFELY AND REQUIRES AN EMT FOR MONITORING OF SAFETY AND LIFE STATUS

3. PT HAS _____ EQUIPMENT AT TIME OF TRANSPORT

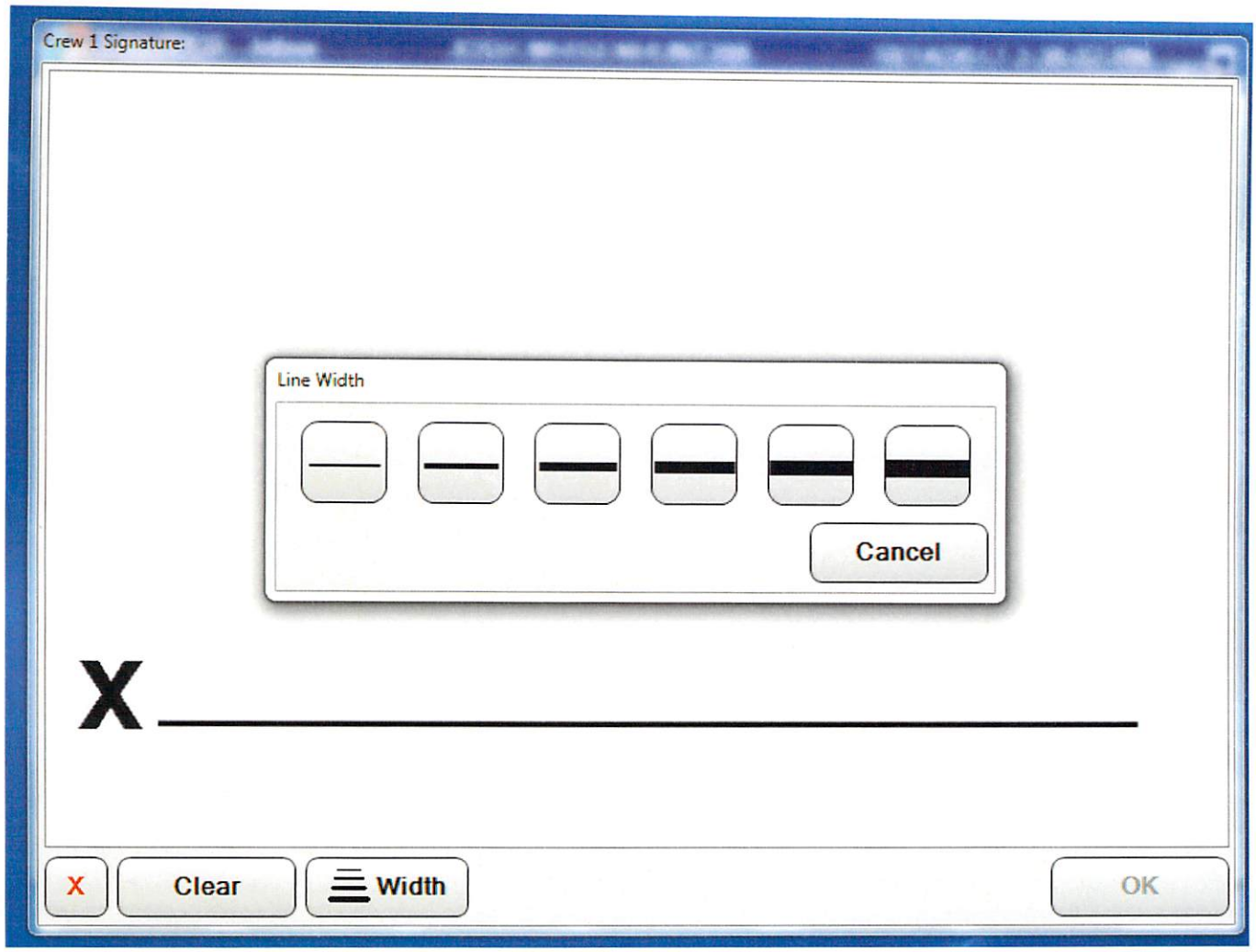
R- ADULT / PED ___ ASSESSMENT, V/S, PULSE OXIMETRY, CBG, _____,_____,_____.

T- PT LOADED ONTO COT VIA ___ EMS PERSONS BY _____. PT PLACED IN _____POSITION OF COMFORT. SECURED PER SAFETY PROTOCOLS. PT TRANSPORTED CODE __ TO _____.

PT HAD _____ CHANGES WHILE IN EMS CARE.

PT REPORT GIVEN VIA PHONE / RADIO.

U/A @ _____ PT PLACED IN _____ BY __ EMS PERSONS VIA_____. PT CARE AND BELONGINGS TURNED OVER TO STAFF.


Crew 1 Signature:
Line Width
Cancel
X
X
Clear
Width
OK

HOPE, AR, 71802
(800) 451-8036

Run Number:
Date of Service:
Patient Name:

X

X Mike Liddell

PO BOX 1120
HOPE, AR, 71802
(800) 451-8036

Run Number:
Date of Service:
Patient Name:

computer did not capture pts signature.

MISCELLANEOUS

Trauma Registry ID:
PD Case Number:
Pat ID Band/Tag #:
Fire Inc Report #:

SIGNATURES

Time	Type	Who signed	Why patient did not sign
	Accept Treatment and Transprt - Crew #	Crew Member #2 - BROOMFIELD, AMANDA D	Hand Contractures

BY SIGNING BELOW, I CERTIFY THAT THE PATIENT WAS PHYSICALLY OR MENTALLY INCAPABLE OF SIGNING AT THE TIME OF TRANSPORT, AND THAT NONE OF THE AUTHORIZED REPRESENTATIVES AS DEFINED IN 42 C.F.R. §424.36(b)(1)-(4) WERE AVAILABLE OR WILLING TO SIGN THE CLAIM ON BEHALF OF THE PATIENT.

x A Broomfield Attest

01/02/2015 06:38	Facility Acceptance	Facility Employee - rn, gary	<Not applicable>

I certify that was received by our facility on the date and time set forth on this report and accept responsibility from crew members RAY, RENAE, BROOMFIELD, AMANDA D.

x

CREW INFORMATION

Start Date/Time :

Crew #	Name	Crew #	Name
	RAY, RENAE		BROOMFIELD, AMANDA
Level:	Mississippi EMS Driver	Level:	EMT-Paramedic

x

x Amanda Broomfield

PO BOX 1120
HOPE, AR, 71802
(800) 451-8036

Run Number:
Date of Service:
Patient Name:

BY SIGNING BELOW, I CERTIFY THAT A COMPLETED AND SIGNED SIGNATURE AUTHORIZATION FORM HAS BEEN OBTAINED, SCANNED AND ATTACHED TO THIS PCR.

X Amanda Broomfield

CREW INFORMATION

Start Date/Time :

Crew #	Name	Crew #	Name
	MURRY, RANDY		BROOMFIELD, AMANDA
Level:	EMT-Basic	Level:	EMT-Paramedic

X _____

X Amanda Broomfield

PAFFORD MEDICAL SERVICES SIGNATURE FORM

PATIENT NAME: This section

DESTINATION LOCATION: must be completed

DATE OF TRANSPORT: including

TIME AT DESTINATION: these

option 1

PATIENT SIGNATURE – (SECTION 1)

I ACKNOWLEDGE THAT I AM LEGALLY RESPONSIBLE FOR THE AMBULANCE SERVICES PROVIDED TO ME. I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE, MEDICAID, AND/OR OTHER INSURANCE BENEFITS BE MADE ON MY BEHALF TO PAFFORD MEDICAL SERVICES FOR ANY SERVICES FURNISHED TO ME BY PAFFORD MEDICAL SERIVCES WHETHER IN THE PAST, NOW OR IN THE FUTURE.

I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME OR OTHER RELEVANT DOCUMENTATION ABOUT ME TO RELEASE TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES AND ITS AGENTS AND CONTRACTORS, ANY AND ALL APPROPRIATE THIRD PARTY PAYORS AND THEIR RESPECTIVE AGENTS AND CONTRACTORS, AS WELL AS TO PAFFORD MEDICAL SERVICES, ANY INFORMATION OR DOCUMENTATION IN THEIR POSSESSION NEEDED TO DETERMINE THESE BENEFITS AND THE BENEFITS PAYABLE FOR RELATED SERVICES WHETHER IN THE PAST, NOW OR IN THE FUTURE.

I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED WITH A COPY OF PAFFORD MEDICAL SERVICES' NOTICE OF PRIVACY PRACTICES ON THIS DATE.

I UNDERSTAND THAT THIS AUTHORIZATION MAY BE USED BY PAFFORD MEDICAL SERVICES FOR ALL SERVICES, WHETHER IN THE PAST, NOW OR IN THE FUTURE UNTIL I REVOKE THIS AUTHORIZATION IN WRITING AND I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

This is prefered — Signature of Patient

Must be dated — Date

option 2

REPRESENTATIVE SIGNATURE – (SECTION 2)

REASON THE PATIENT IS PHYSICALLY OR MENTALLY INCAPABLE OF SIGNING **(MUST BE COMPLETED BY CREW OR REPRESENTATIVE):**

You have to have a Reason here if you use this section

BY SIGNING BELOW, I AFFIRM I AM ONE OF THE FOLLOWING INDIVIDUALS, AND I AM SIGNING ON BEHALF OF THE PATIENT. I UNDERSTAND THAT I AM SIGNING IN ORDER TO PERMIT THE ABOVE NAMED COMPANY TO SUBMIT A CLAIM FOR ITS SERVICES TO MEDICARE AND ALL OTHER PAYORS. **MY SIGNATURE IS NOT AN ACCEPTANCE OF FINANCIAL RESPONSIBILITY FOR THE PATIENT.**

(MUST CHECK ONE):

- ☐ PATIENT'S LEGAL GUARDIAN
- ☐ RELATIVE OR OTHER PERSON WHO RECEIVES GOVERNMENTAL BENEFITS ON THE PATIENT'S BEHALF
- ☐ RELATIVE OR OTHER PERSON WHO ARRANGES PATIENT'S TREATMENT OR MANAGES THE PATIENT'S AFFAIRS
- ☐ REPRESENTATIVE OF AN AGENCY OR INSTITUTION THAT FURNISHED CARE OR OTHER SERIVCES TO THE PATIENT

Read & select

Signature of Representative | Printed Name of Representative | Date

option 3

AMBULANCE CREW AND RECEIVING FACILITY SIGNATURE – (SECTION 3)

COMPLETE THIS SECTION ONLY IF: (1) THE PATIENT WAS PHYSICALLY OR MENTALLY INCAPABLE OF SIGNING, AND (2) NO AUTHORIZED REPRESENTATIVE WAS AVAILABLE OR WILLING TO SIGN ON BEHALF OF THE PATIENT

(A) AMBULANCE CREW MEMBER STATEMENT

BY SIGNING BELOW, I CERTIFY THAT THE ABOVE-NAMED PATIENT WAS PHYSICALLY OR MENTALLY INCAPABLE OF SIGNING AT THE TIME OF TRANSPORT AND THAT NONE OF THE AUTHORIZED REPRESENTATIVES AS DEFINED IN 42 C.F.R. §424.36(b)(1)-(4) AND LISTED IN SECTION 2 WAS AVAILABLE OR WILLING TO SIGN THE CLAIM ON BEHALF OF THE PATIENT.

REASON THE PATIENT IS PHYSICALLY OR MENTALLY INCAPABLE OF SIGNING **(MUST BE COMPLETED BY CREW):**

You have to fill this out if you use this section

Signature of Crew member | Printed Name of Crew member | Date

(B) RECEIVING FACILITY REPRESENTATIVE SIGNATURE OR ☐ **RECEIVING FACILITY REP SIGNATURE OBTAINED ON SHORT FORM**

THE ABOVE-NAMED PATIENT WAS RECEIVED AT OUR FACILITY ON THE DATE AND TIME SET FORTH ABOVE.

Signature of Representative | Printed Name of Representative | Date

(SAF V.0213)

PAFFORD MEDICAL SERVICES

Zoll EPCR Attachment Flow Sheet

Pt. Name: _____
First Middle Last

DOS: _____/_____/_____

Run #: _____

Unit #: _____

_____ Face Sheet

_____ EKG Strip

_____ CMN (Original?, Signed?, Dated?, Same as above?)

_____ EMTALA Form

_____ Other:_____

_____ Other:_____

Crew: _____ _____
Medic Driver/EMT

*****Please ensure that ALL pages have the DOS & Run # on them*****

Yazoo ← EXAMPLE → Hall County worked to top.

Pafford EMS

Zoll EPCR Attachment Flow Sheet

Date of Service

Pt. Name: John (First) Middle Doe (Last)

NOT Date of Birth

DOS: ____/____/____

Run #: 17 (year) 999999 (Run #)

Unit #: 473

✓ Face Sheet

____ EKG Strip

____ CMN (Original?, Signed?, Dated?, Same as above?) > Medical necessity

✓ EMTALA Form / Transfer form

____ Other: narcotic form

____ Other: Signature form, HIPP, ect

Crew:

Medic > who rode in the back - can be BASIC

Driver/EMT

*****Please ensure that ALL pages have the DOS & Run # on them*****

Old FORM

Pafford EMS
Zoll EPCR Attachment Flow Sheet

____Madison ✓ Rankin ____Yazoo ____Warren ____Washington

DOS: 2 / 15 / 2018 *not date of birth*
(Year)

Run #: 18 . 9999 (Run#)

Unit #: 473

Pt. Name: Wolly Wagon
First Middle Last

✓ Face Sheet

✓ EKG Strip/12 Lead

✓ CMN (Original, Signed, Dated, Same as above)

✓ EMTALA Form } also known as transfer form

____Narc Form

____MVA Form

____Belongings Form

____Paper Refusal

____ Other

Dont scan & throw away documents.
Scan, Attach, & turn them in.

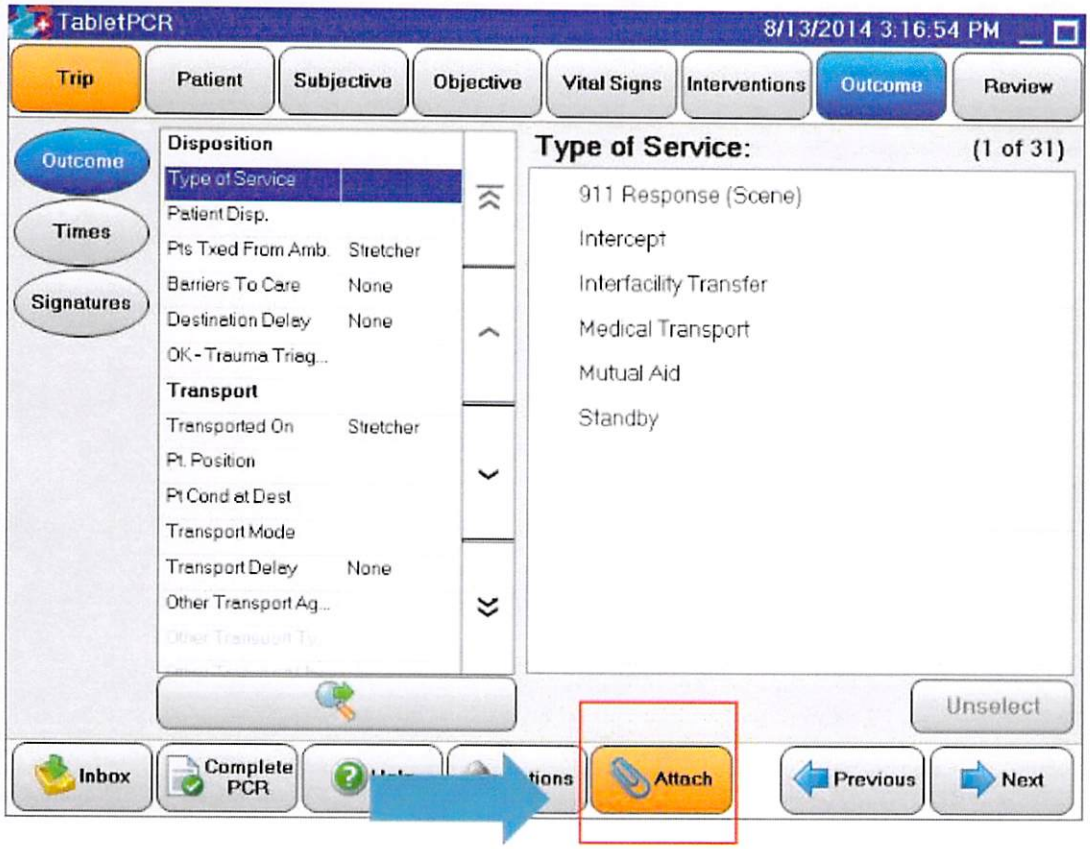
Meagan Johnson
Medic/Basic

Daniel Mabus
Driver/Basic/Medic

Full & legible names

****Please ensure that ALL pages have the DOS & Run# on them****

PAFFORD MEDICAL SERVICES



VERIFY THAT THIS IS ILLUMINATED GOLD BY CLICKING ON ANY OF THE TOP ROW OF BUTTONS AFTER YOU HAVE ADDED YOUR ATTACHMENTS TO THE PCR.

THIS WILL HELP ENSURE THAT THE ATTACHMENTS ARE ON THE REPORT BEFORE IT IS SENT TO THE SERVER.

THANK YOU

MOTOR VEHICLE INFORMATION SHEET

PLEASE CIRCLE: SINGLE OR MULTIPLE ACCIDENT
LAW ENFORCEMENT ON SCENE: _____

VEHICLE #1 - DRIVER'S NAME: _____
OWNER'S NAME: _____
AUTO INS NAME: _____
ADDRESS: _____
POLICY NUMBER: _____
NAME OF PTS TRANSPORTED: _____
INCLUDE NAMES OF NPUS NOT
TRANSPORTED: _____
MAKE/MODEL OF VEHICLE: _____

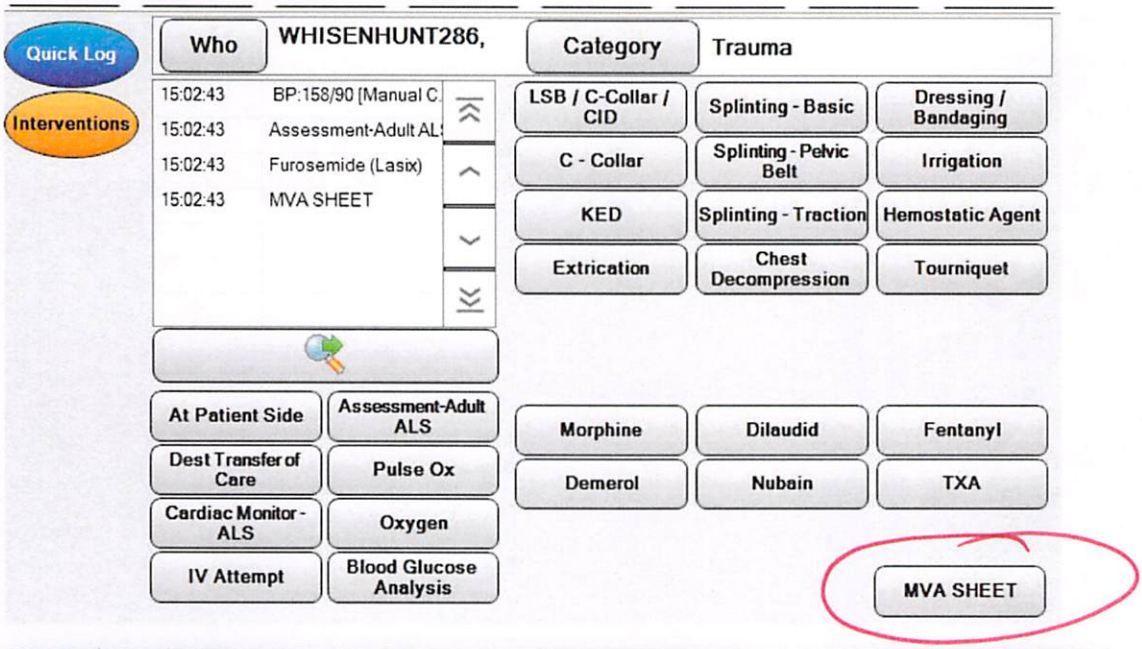
VEHICLE #2 - DRIVER'S NAME: _____
OWNER'S NAME: _____
AUTO INS NAME: _____
ADDRESS/PHONE: _____
POLICY NUMBER: _____
NAME OF PTS TRANSPORTED: _____

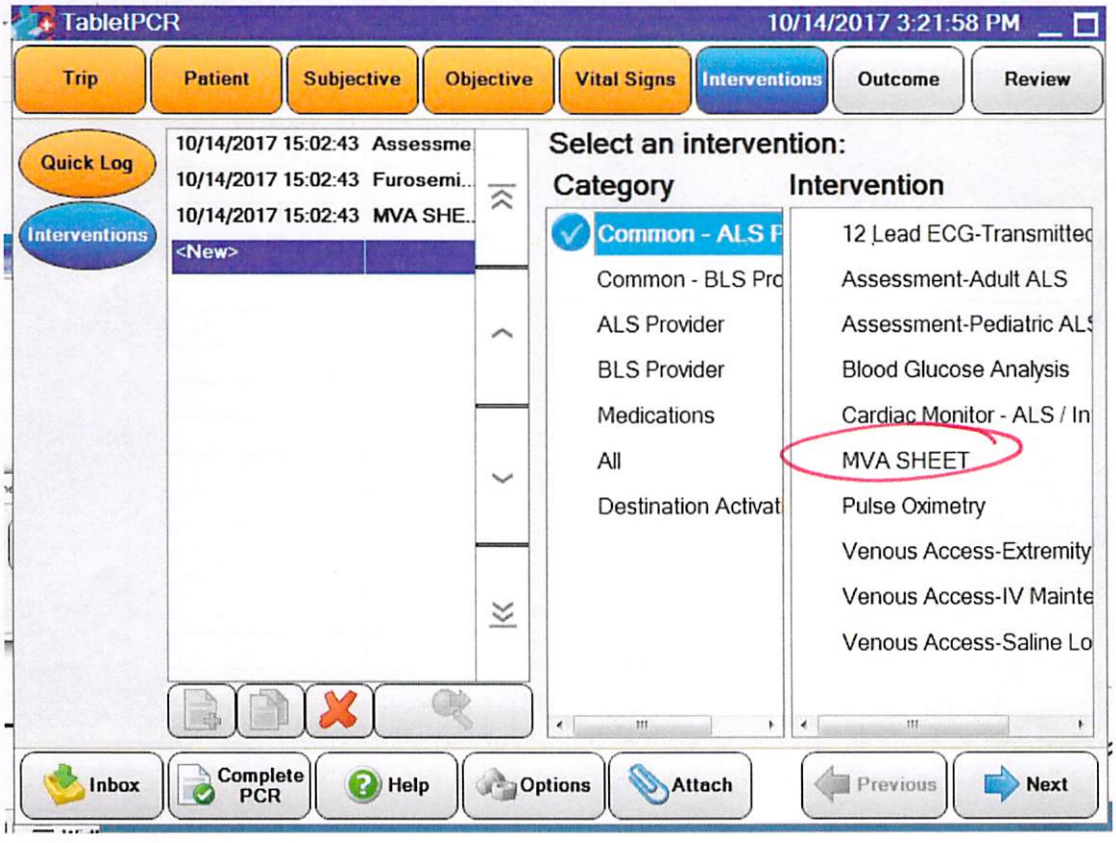
INCLUDE NAMES OF NPUS NOT TRANSPORTED: _____

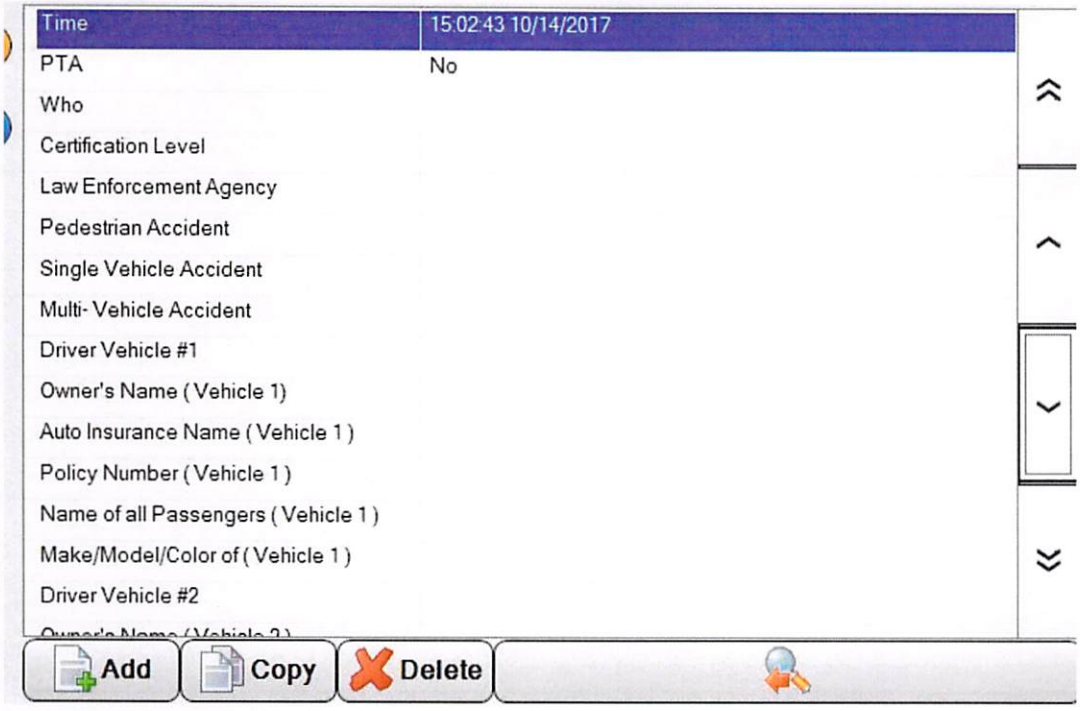
MAKE/MODEL OF VEHICLE: _____

PLEASE ATTACH ADDITIONAL INFORMATION IF NEEDED IF MORE THAN 2 VEHICLE ACCIDENT.

MVA SHEET


Quick Log
Interventions
Who
WHISENHUNT286,
Category
Trauma
15:02:43 BP:158/90 [Manual C.
15:02:43 Assessment-Adult AL
15:02:43 Furosemide (Lasix)
15:02:43 MVA SHEET
LSB / C-Collar / CID
Splinting - Basic
Dressing / Bandaging
C - Collar
Splinting - Pelvic Belt
Irrigation
KED
Splinting - Traction
Hemostatic Agent
Extrication
Chest Decompression
Tourniquet
At Patient Side
Assessment-Adult ALS
Dest Transfer of Care
Pulse Ox
Cardiac Monitor - ALS
Oxygen
IV Attempt
Blood Glucose Analysis
Morphine
Dilaudid
Fentanyl
Demerol
Nubain
TXA
MVA SHEET


TabletPCR
10/14/2017 3:21:58 PM
Trip
Patient
Subjective
Objective
Vital Signs
Interventions
Outcome
Review
Quick Log
Interventions
10/14/2017 15:02:43 Assessme
10/14/2017 15:02:43 Furosemi..
10/14/2017 15:02:43 MVA SHE..
<New>
Select an intervention:
Category
Intervention
Common - ALS P
Common - BLS Pro
ALS Provider
BLS Provider
Medications
All
Destination Activat
12 Lead ECG-Transmitted
Assessment-Adult ALS
Assessment-Pediatric ALS
Blood Glucose Analysis
Cardiac Monitor - ALS / In
MVA SHEET
Pulse Oximetry
Venous Access-Extremity
Venous Access-IV Mainte
Venous Access-Saline Lo
Inbox
Complete PCR
Help
Options
Attach
Previous
Next



MOTOR VEHICLE INFORMATION SHEET

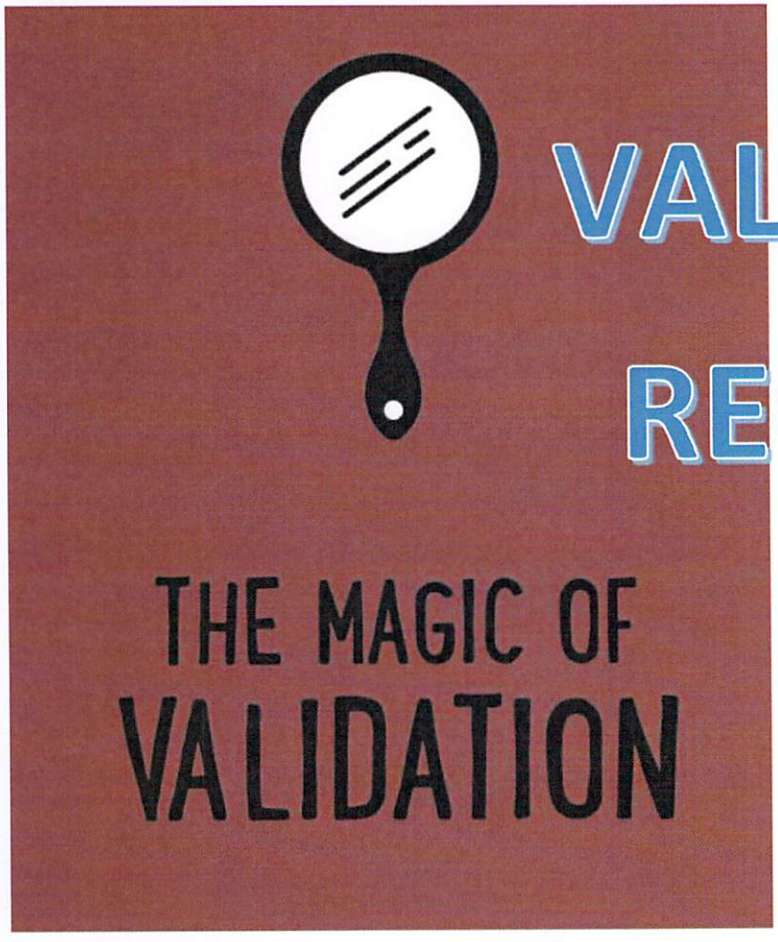
PLEASE CIRCLE: SINGLE OR MULTIPLE ACCIDENT
LAW ENFORCEMENT ON SCENE: _____

VEHICLE #1 - DRIVER'S NAME: _____
OWNER'S NAME: _____
AUTO INS NAME: _____
ADDRESS: _____
POLICY NUMBER: _____
NAME OF PTS TRANSPORTED: _____
INCLUDE NAMES OF NPUS NOT
TRANSPORTED: _____
MAKE/MODEL OF VEHICLE: _____

VEHICLE #2 - DRIVER'S NAME: _____
OWNER'S NAME: _____
AUTO INS NAME: _____
ADDRESS/PHONE: _____
POLICY NUMBER: _____
NAME OF PTS TRANSPORTED: _____
_____
INCLUDE NAMES OF NPUS NOT TRANSPORTED: _____
_____
MAKE/MODEL OF VEHICLE: _____

PLEASE ATTACH ADDITIONAL INFORMATION IF NEEDED IF
MORE THAN 2 VEHICLE ACCIDENT.

PAFFORD
MEDICAL SERVICES

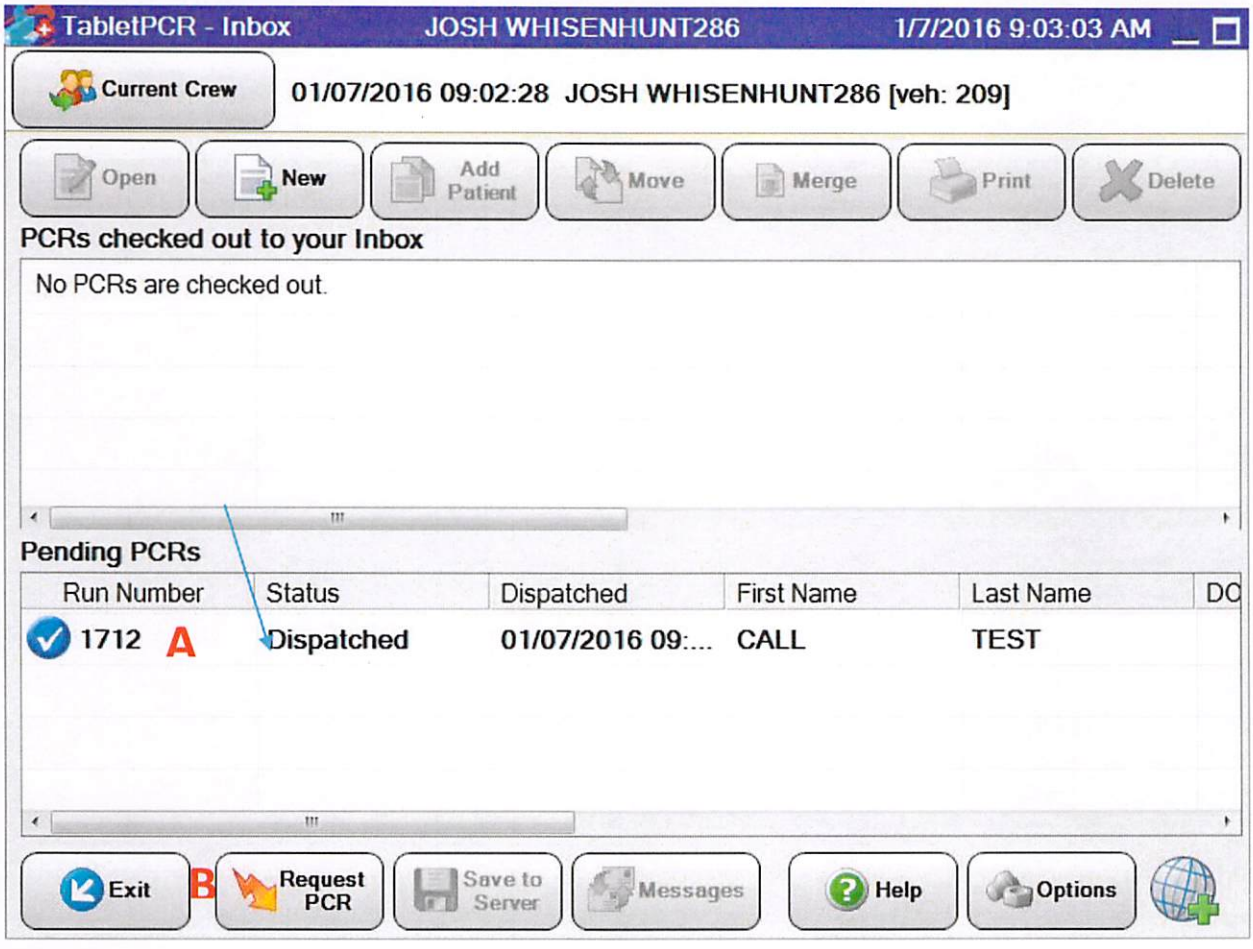


VALIDATION REQUIRED

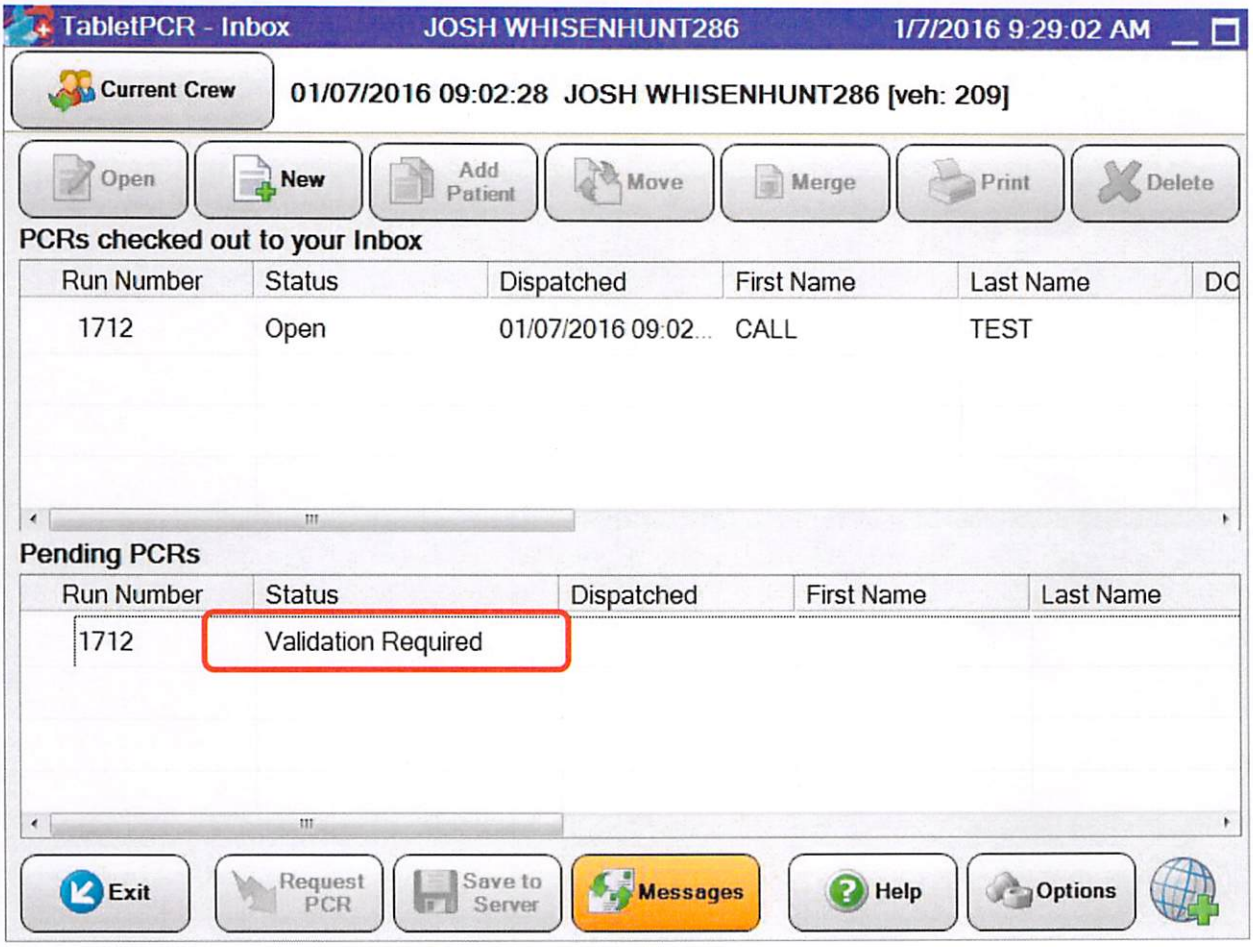
Pending PCRs

Run Number	Status	Dispatched	First Name	Last Name
	Validation Required			

Request the "Dispatched PCR" as indicated below by tapping the run number **A**, and then tapping "Request PCR" **B**. Open the PCR and Complete it as you normally would have completed a "New" PCR.

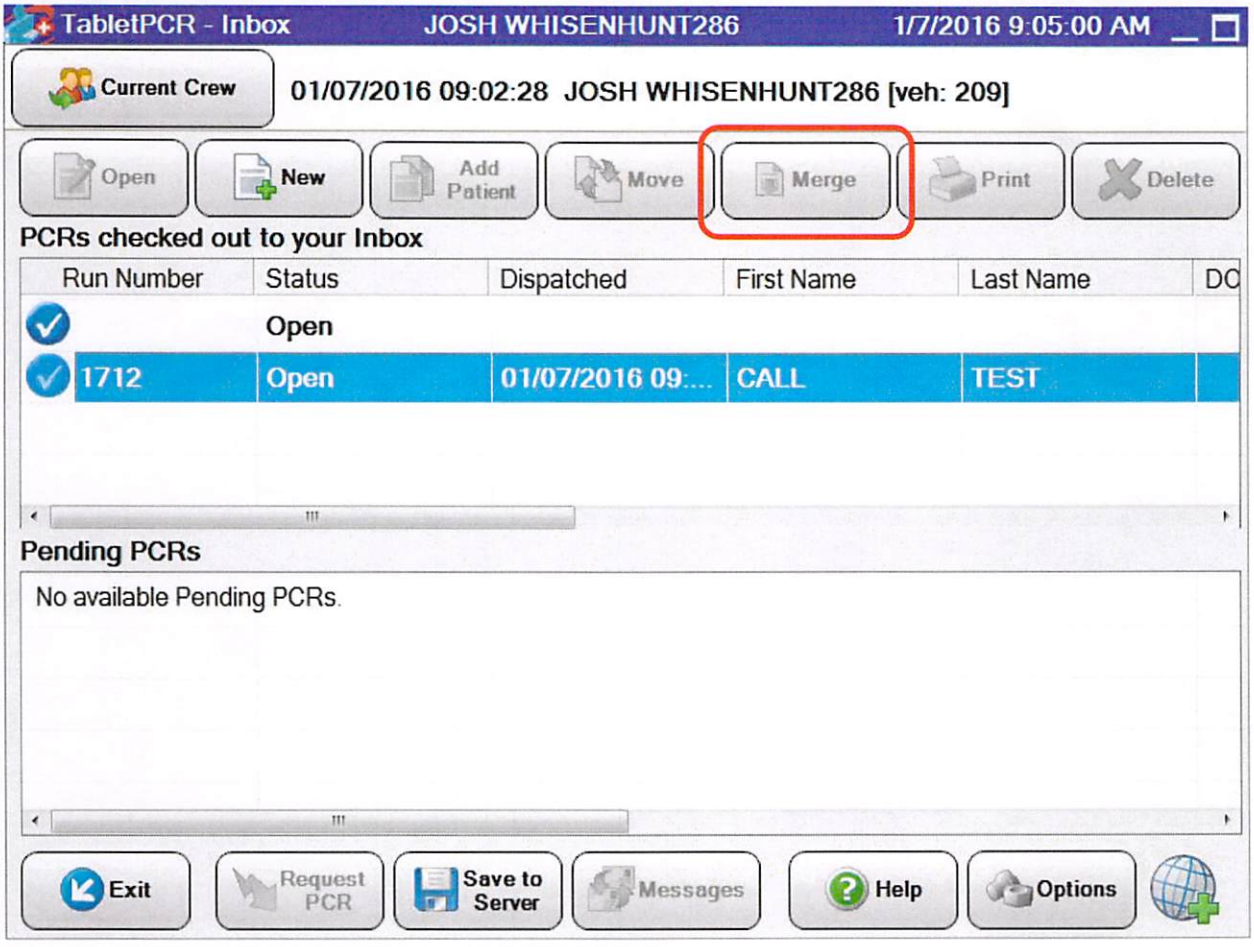


If you fail to use a "Dispatched" PCR, and create one from "New", upon completion, when you save the call to the server, it will enter a processing status called "Validation Required". To correct this error, you must "Merge" a "Dispatched PCR" the the PCR you created from "New". This Process is outlined below.



Select Both PCRS by tapping them, and notice that the "Merge" button has not been activated for use.

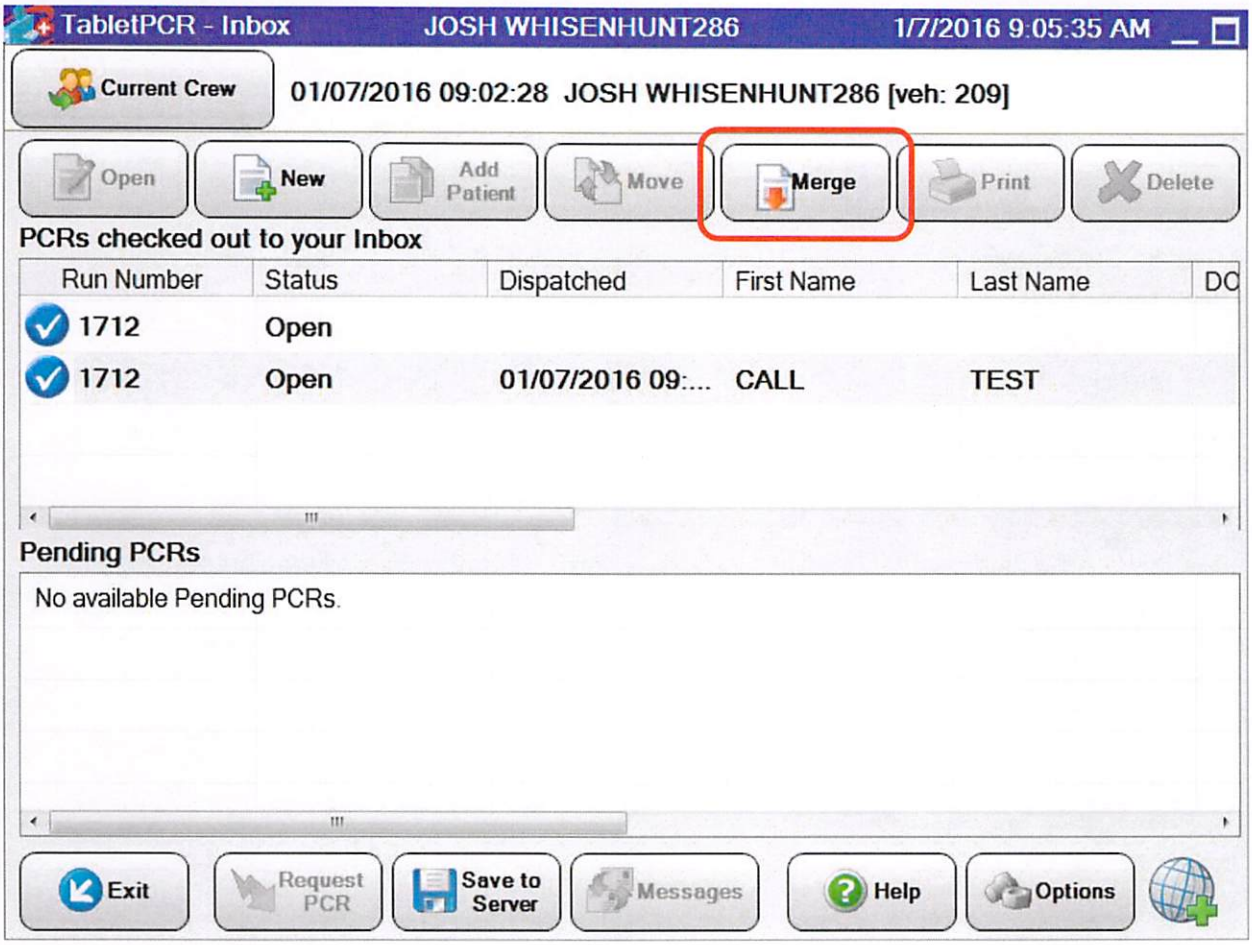
Both Run numbers must be identical in order to Merge the 2 PCRs into 1.



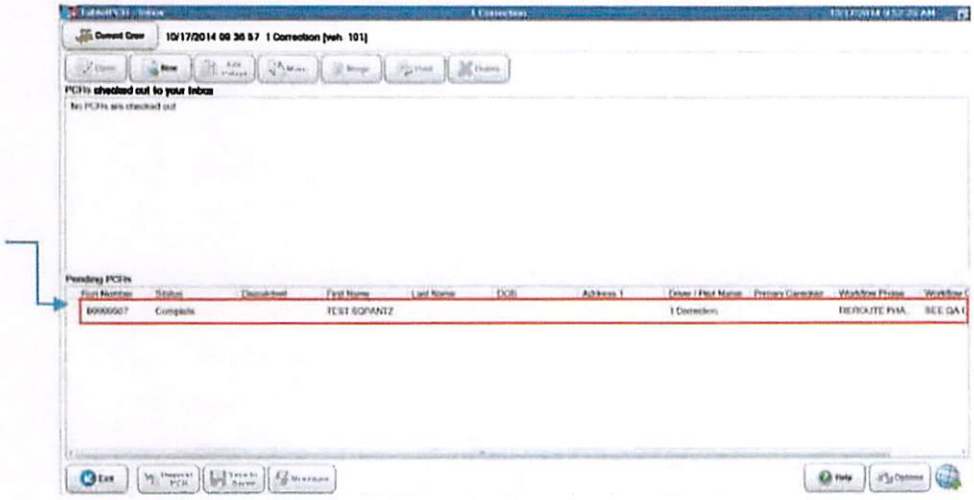
With both PCRs Having Matching Run Numbers, the Merge button illuminates.

Tap "Merge" and the two PCRs will become 1.

>>> NOTE: This cannot be un-done. Once two PCRs are "Merged" you cannot reverse the process.



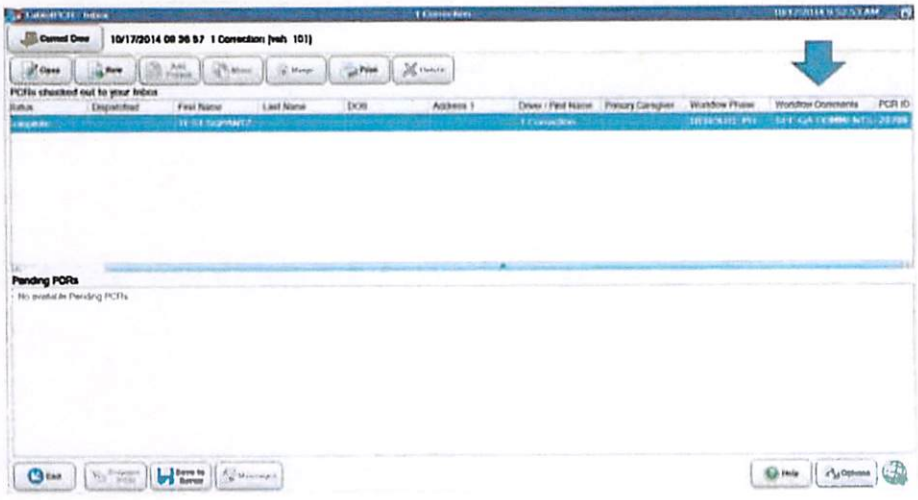
PCRs Returned to Users



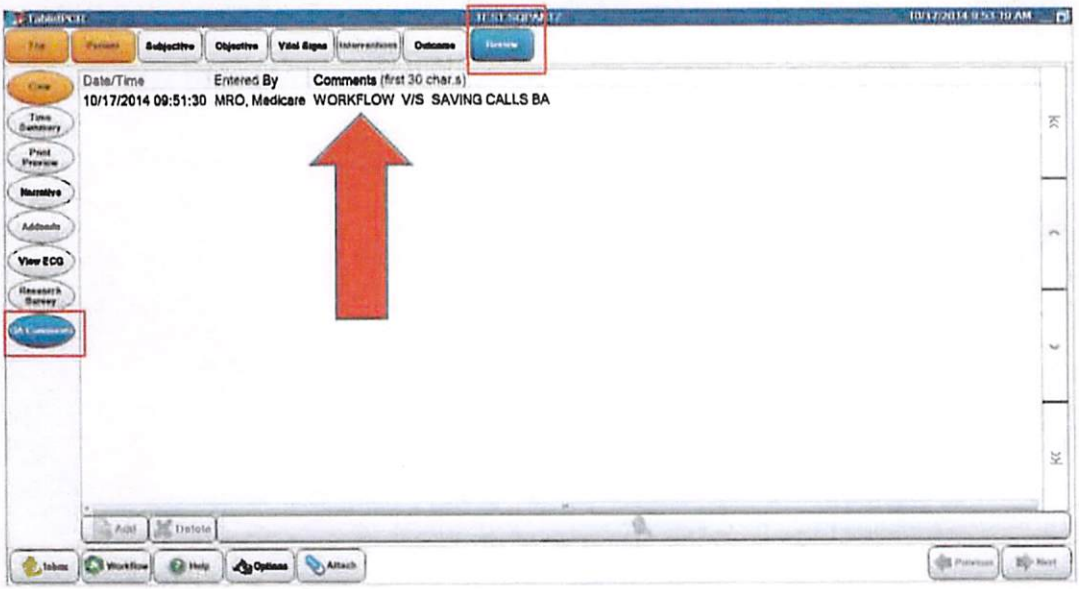
If a PCR appears in your inbox in a COMPLETE status, it has been returned to you.

A. It might have a Billing QA issue
B. It might have a Clinical QA issue

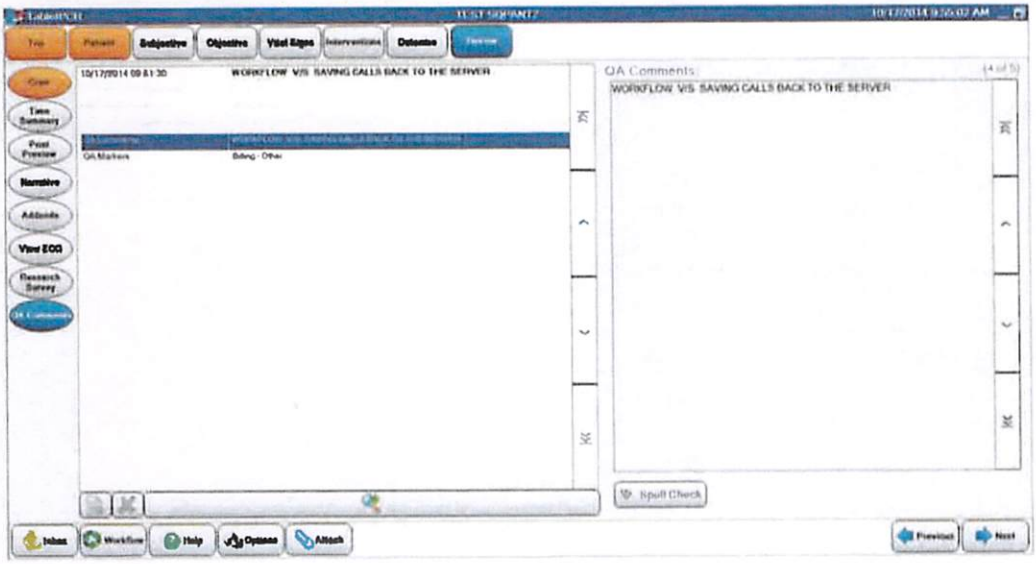
Check the workflow comments once you have requested the PCR from the server.



Open the PCR and it will automatically open to the Review Tab, the QA Comment form.



Click to open the comment entered by Billing or QA department.



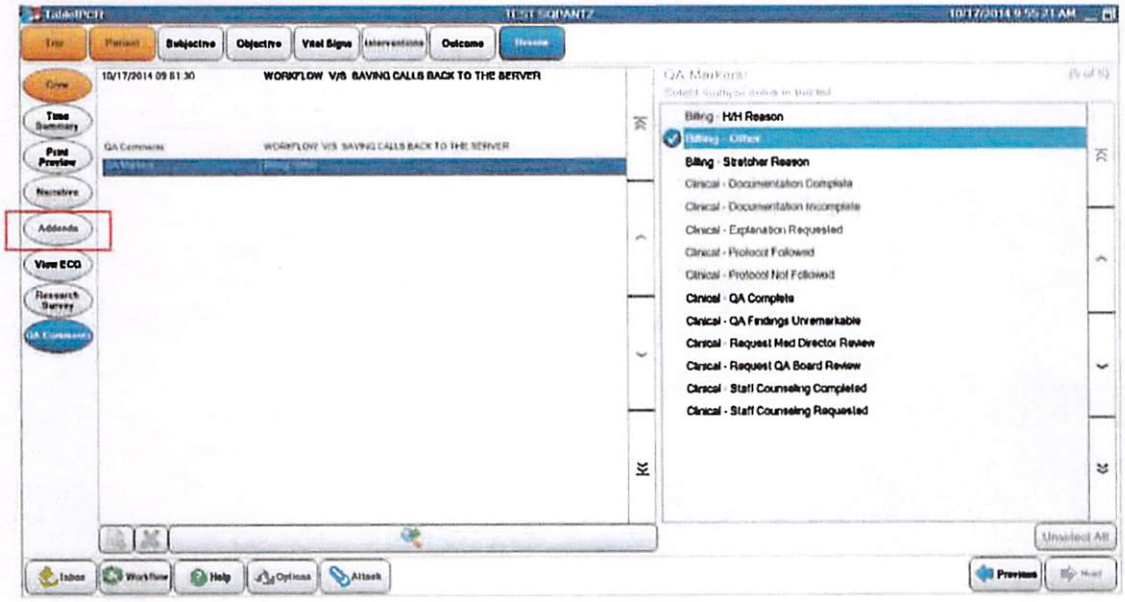
This screen will open giving the details of why the PCR was returned to the user.

There are 2 types of QA

QA- Markers & QA Comments

Billing- These will generally require some additional information on the PCR or work to be done to areas of the report for proper and prompt billing of claims. PCRs that are returned for corrections will **require** an addenda. Utilize the Addenda tab on the left to complete this action.

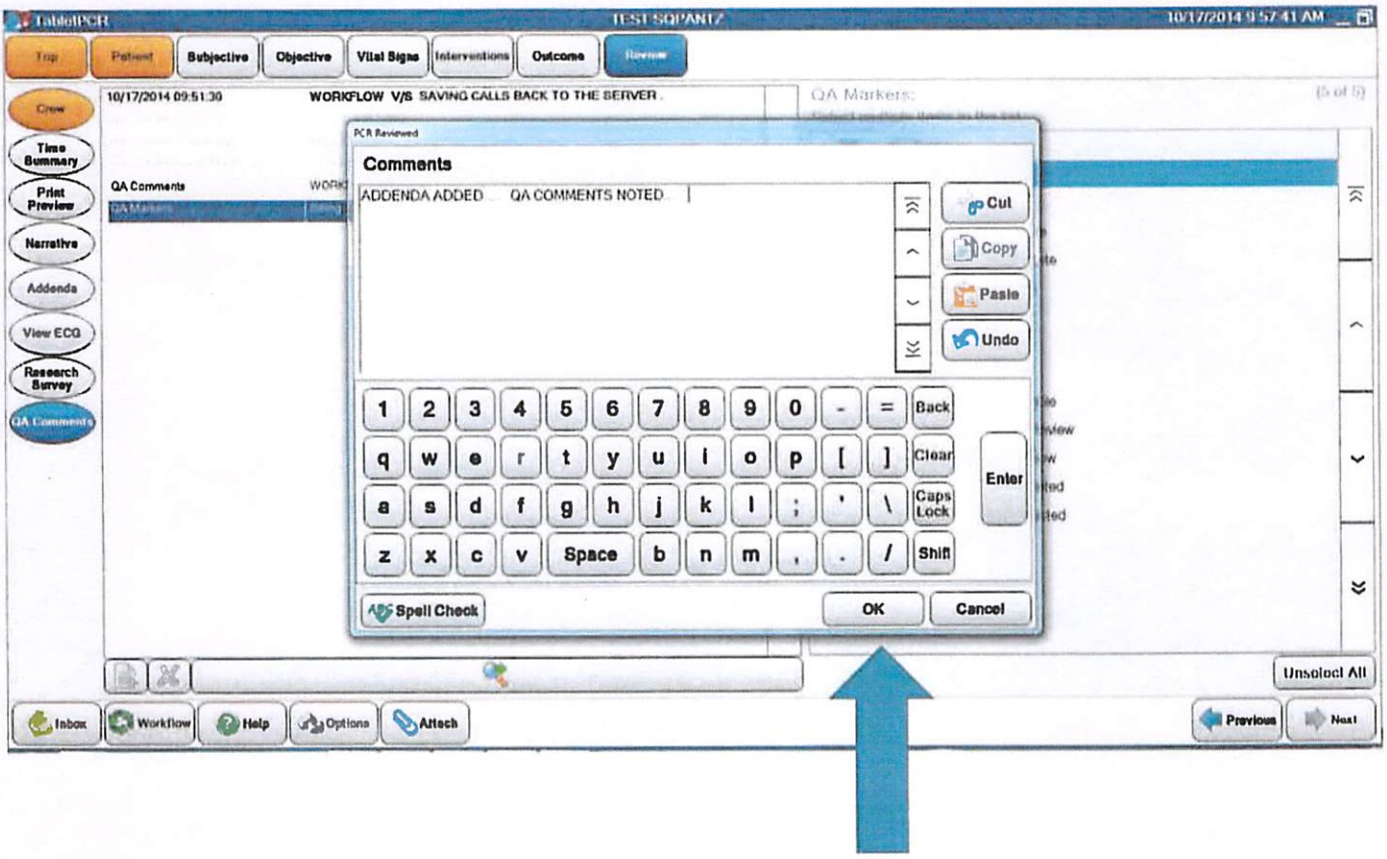
Clinical- These may or may not require additional work to be done on the PCR, and these may be for quality improvement purposes as well as to note for future educational use.



After correcting the problem with the PCR or taking note of why the PCR was returned it will have to be sent back to the sending authority.

THIS CAN ONLY BE DONE BY UTLITIZING THE WORKFLOW BUTTON

A screen will appear (PCR Reviewed) this is for the user to enter that the run has been corrected, an addenda added, or comments noted. Just something to acknowledge that the PCR is ready to go back to the sender.



******** The user will have to enter a message in order to continue. *********

Push OK !! THE PCR WILL NO LONGER BE IN THE USERS INBOX.

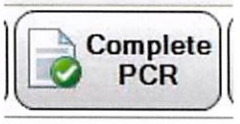
** IF THE USER DOES NOT HIT THE 

BUTTON AND JUST SAVES THE PCR TO THE SERVER IT WILL NOT EVER LEAVE THE USERS INBOX.**

THANK YOU!!

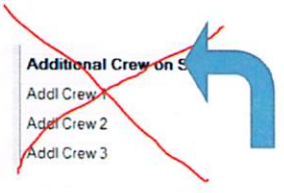
Additional data collection for validation

Tips to assist and reduce time during the Complete PCR phase

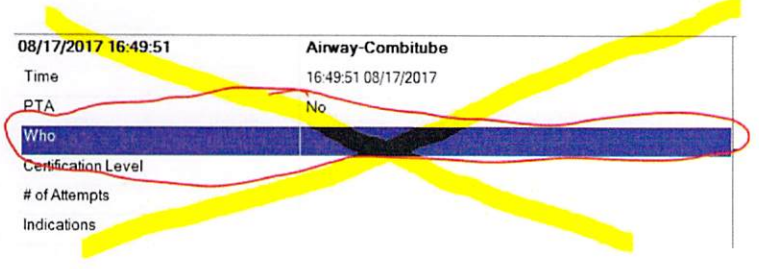


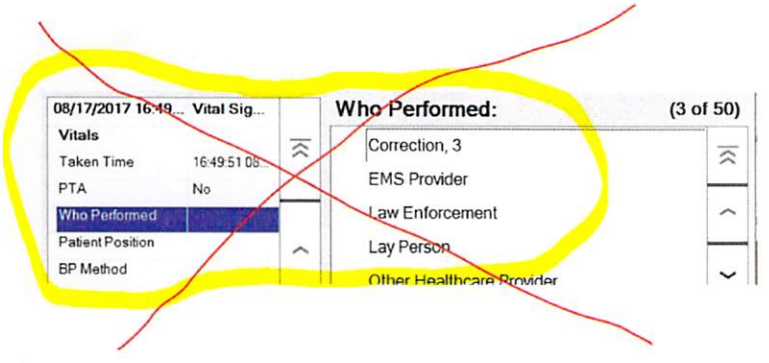
Below is a not value button and can be useful in places which no other values are a valid choice.  In some further examples we will demonstrate where this use of this should take place.

If a person's name (Pafford Crew) is not in the crew set up do not put that person's name anywhere on the report. Only the staff whom are in the crew set up under the REVIEW Tab can be the persons who are the answers for any of the following fields in vital signs and / or interventions.

Ex. 

You cannot select a Pafford Crew from the list. You must select can't find and type in the name if it is a Pafford Employee.





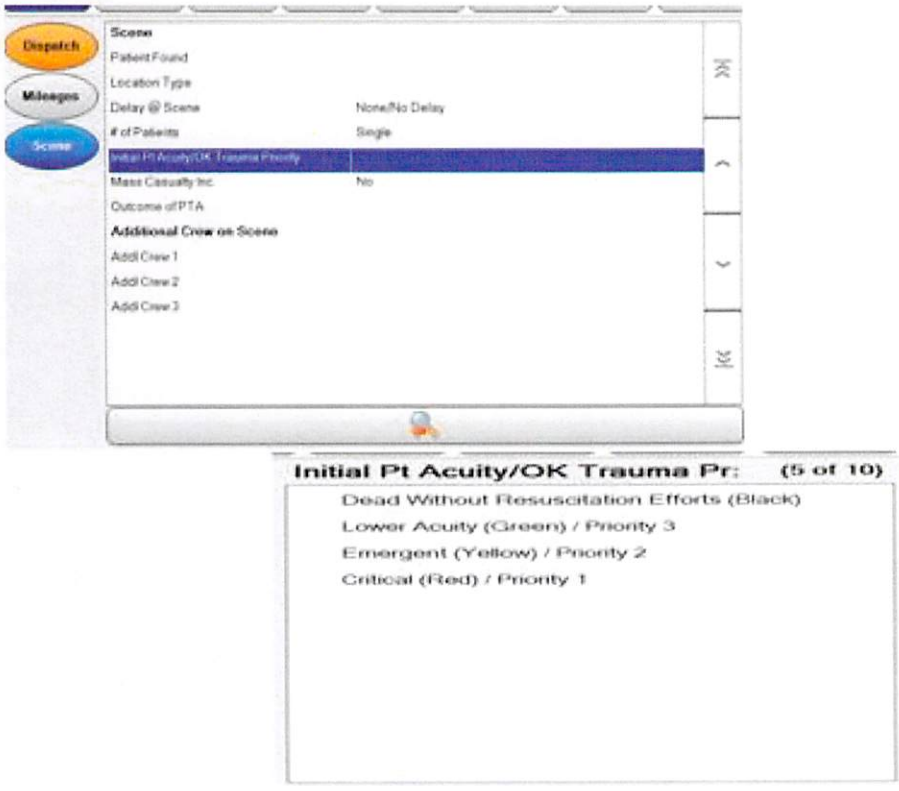
Patient Acuity

These definitions match the *Model of Clinical Practice of Emergency Medicine* and acknowledge that the patient's acuity level is essential for identifying priorities for care in the out-of-hospital setting.

Critical	Emergent	Lower Acuity
Patient presents with symptoms of a life-threatening illness or injury with a high probability of mortality if immediate intervention is not begun to prevent further airway, respiratory, hemodynamic and/or neurologic instability.	Patient presents with symptoms of an illness or injury that may progress in severity or result in complications with a high probability for morbidity if treatment is not begun quickly.	Patient presents with symptoms of an illness or injury that have a low probability of progression to more serious disease or development of complications.

Initial Pt Acuity / OK Trauma Priority

This is a required field and is located in the TRIP TAB under the SCENE section. Please see the appendix on acuity in section 7 of this guide Final Patient Acuity for further descriptors.



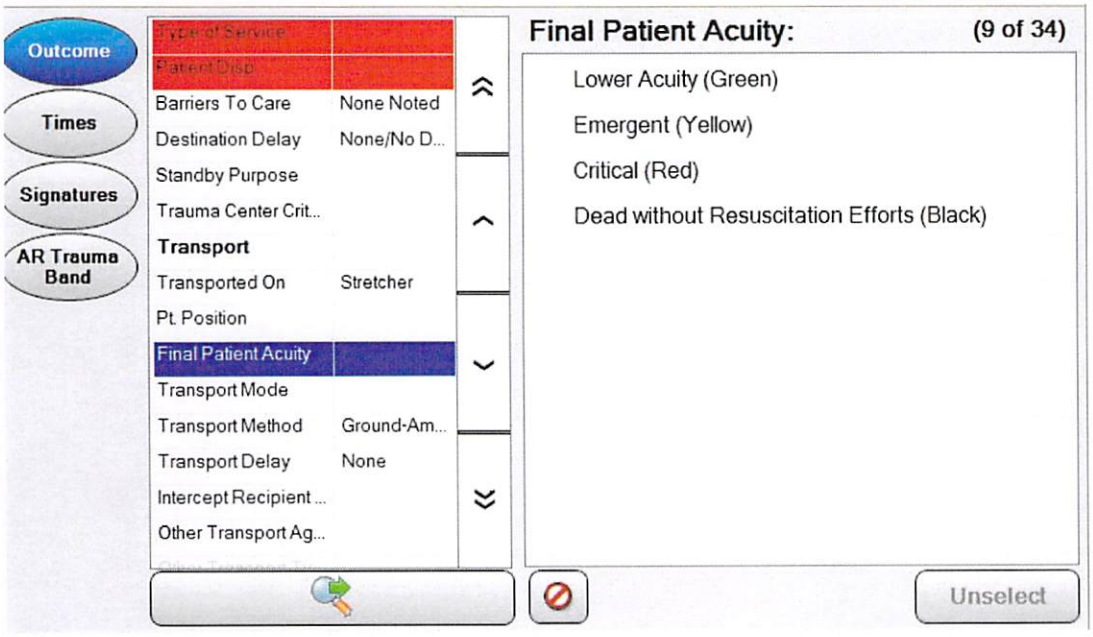
Final Patient Acuity

These definitions match the *Model of Clinical Practice of Emergency Medicine* and acknowledge that the patient's acuity level is essential for identifying priorities for care in the out-of-hospital setting.

Critical	Emergent	Lower Acuity
Patient presents with symptoms of a life-threatening illness or injury with a high probability of mortality if immediate intervention is not begun to prevent further airway, respiratory, hemodynamic and/or neurologic instability.	Patient presents with symptoms of an illness or injury that may progress in severity or result in complications with a high probability for morbidity if treatment is not begun quickly.	Patient presents with symptoms of an illness or injury that have a low probability of progression to more serious disease or development of complications.

This field is located under the OUTCOME tab and in the OUTCOME section.

State Rule 7/10 — Final Patient Acuity Not Documented



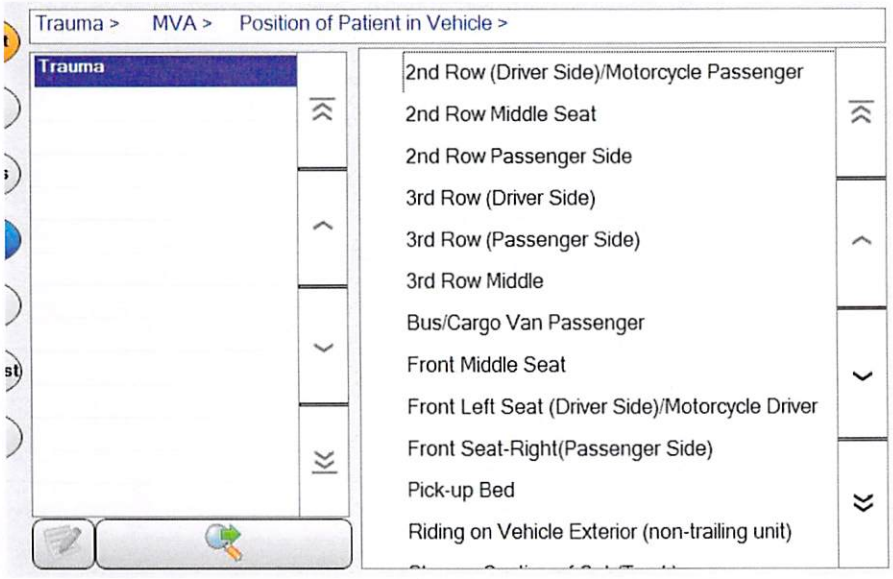
State Rule 5/10 — Based on Incident/Patient Disposition, the following should be recorded: Final Patient Acuity, Destination Patient Transfer of Care Date/Time

MVA

PT position in seat/vehicle relocated

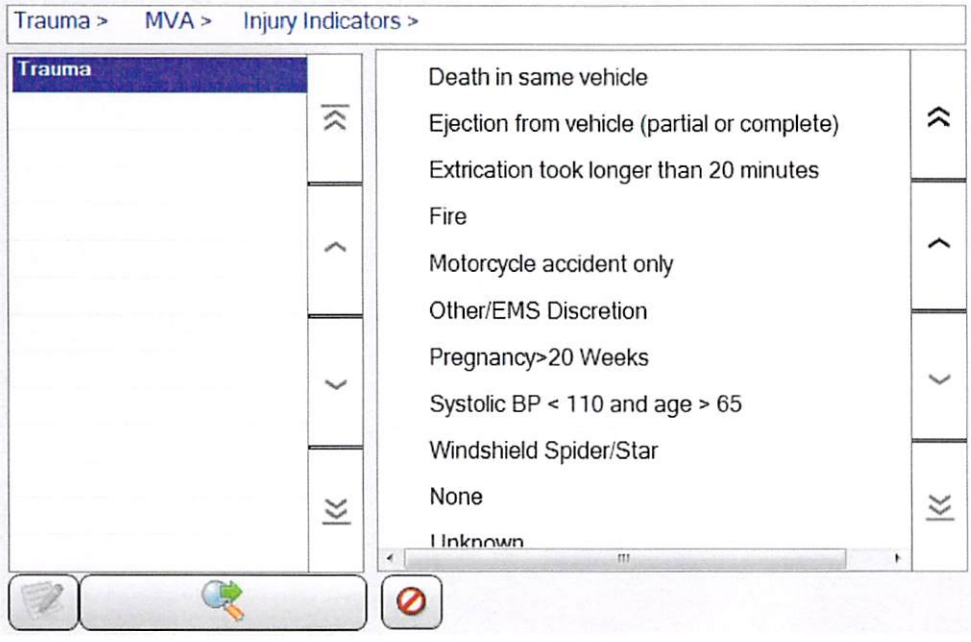
All MVA's require a patient position and this field has moved from the OTHER section under the OBJECTIVE TAB to the Trauma Tree.

Trauma > MVA > Position of Patient in Vehicle



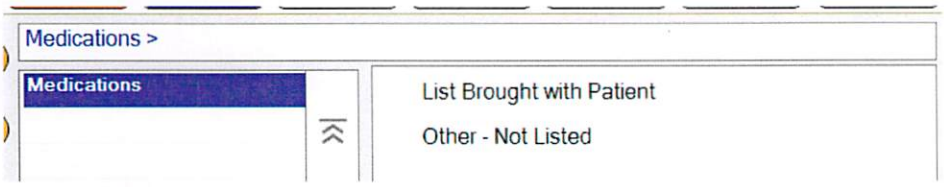
MVA's require an injury indicator

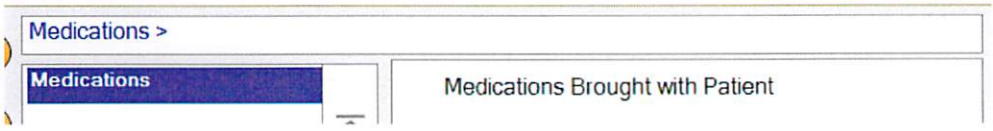
Trauma > MVA > Injury Indicators or N/A



MEDICATIONS

When possible and it is not interrupting good quality patient care. It is better to document what the patient is actually taking rather than the use of list or meds brought with patient. If you have a list or if the patient has brought them then you should be able to report to the state what they are correct?





If no medications are with the patient use  select the most appropriate choice.

OTHER ASSOCIATED SYMPTOMS

At times a patient may have more than one complaint sign or symptom of an illness and / or injury yet other times the patient may only present with a single problem. In an occurrence such as this the other associated symptoms would flag a state rule as shown below.

State Rule 9/10	Other Associated Symptoms Not Documented or Select Not Applicable

You don't want to leave the other associated symptoms blank or each time you attempt to run the complete call rules this item will be triggered slowing down the process of locking out the trip ticket.

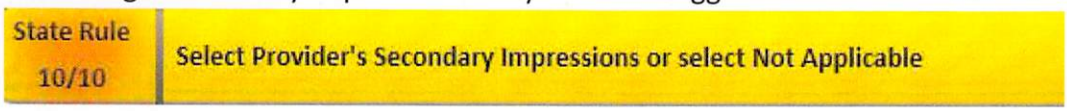
Associated Symptoms

Primary Symptom	Altered mental status
Other Assoc. Symp.	Ø:Not Applicable

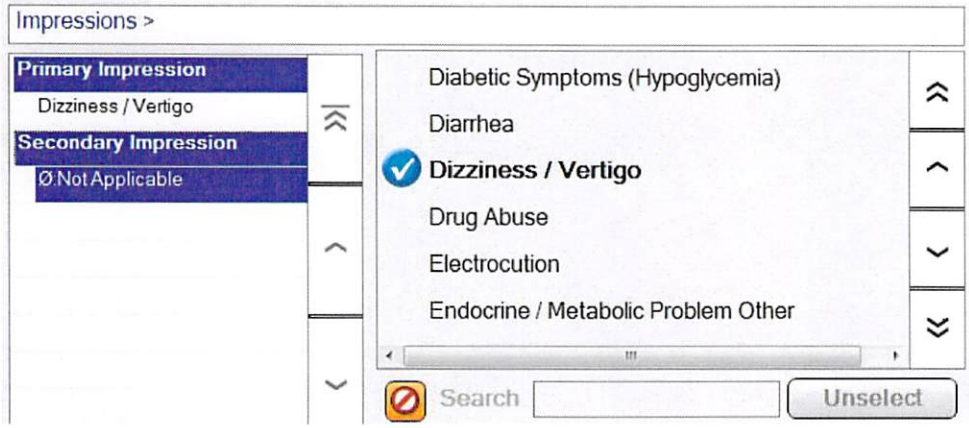
Resolve by adding "Not Applicable"  .

PROVIDER IMPRESSION

The ambulance staff's provider impressions can also work in the same manner. Without answering a Secondary Impression the system will trigger a State Rule as shown below.



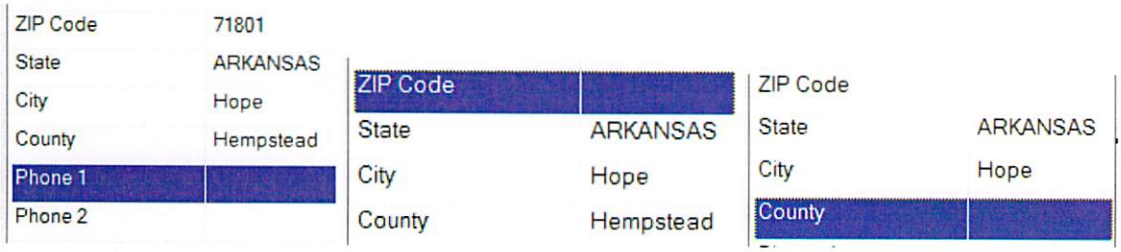
If no applicable Secondary Impression applies select the "Not Applicable" button. 

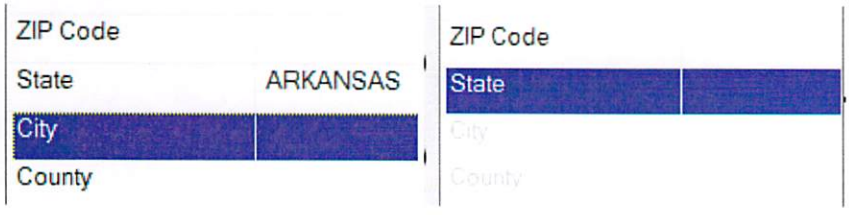


ADDRESS REMOVAL

Pick-up Physical Mailing NOK Drop off

To remove and address from the PCR you have to move in an inverted order. Clear out the Zip Code then work from the bottom to the top.



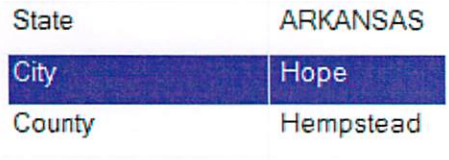


You have to remove the county first then take out the city and last take out the state.

If you have accidently taken out the state before the county and the city the program will lock out the fields below the state as you can see in this example.

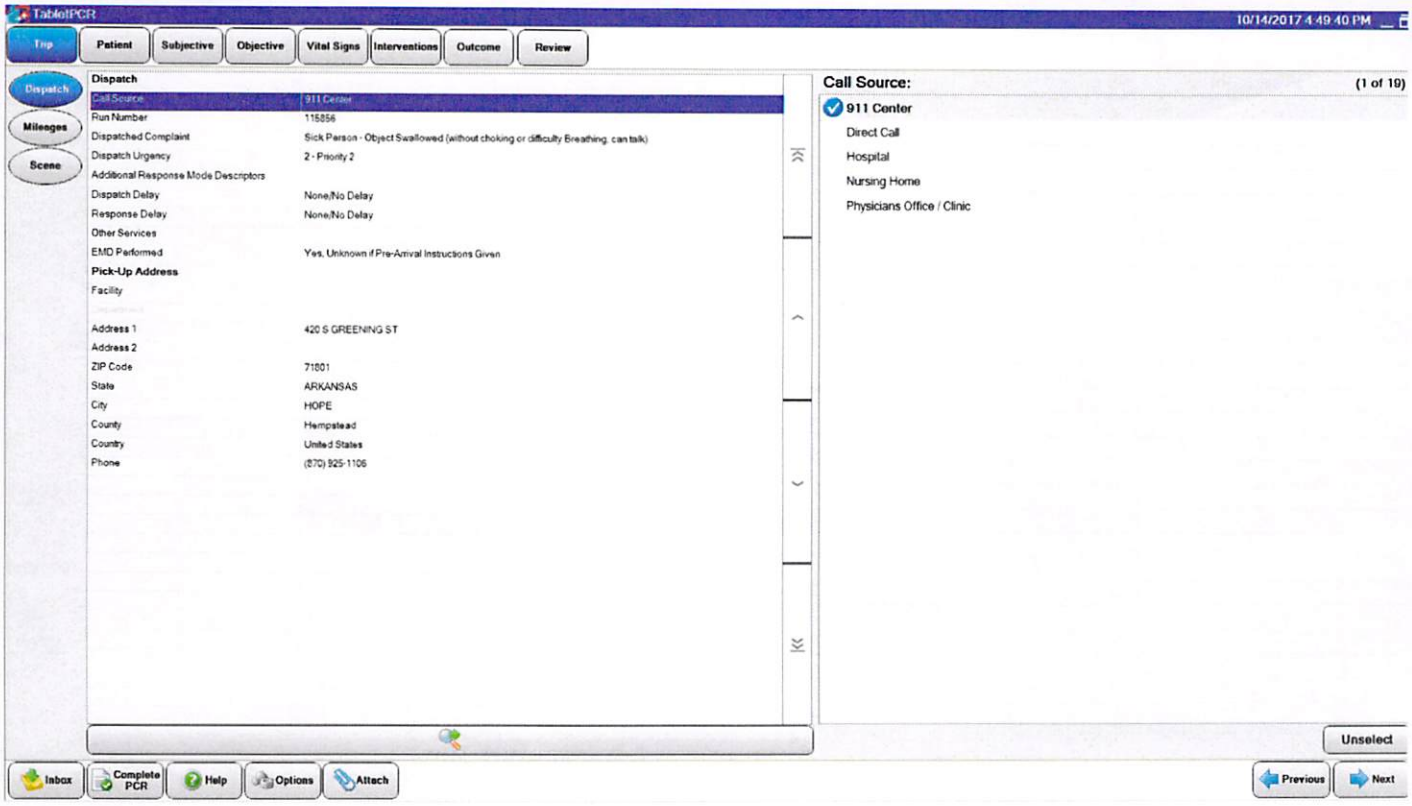
The EPCR system will trigger a CCR stating if a physial address is present you must have a mailing address and / or if a mailing address is present you must have a physical addess.

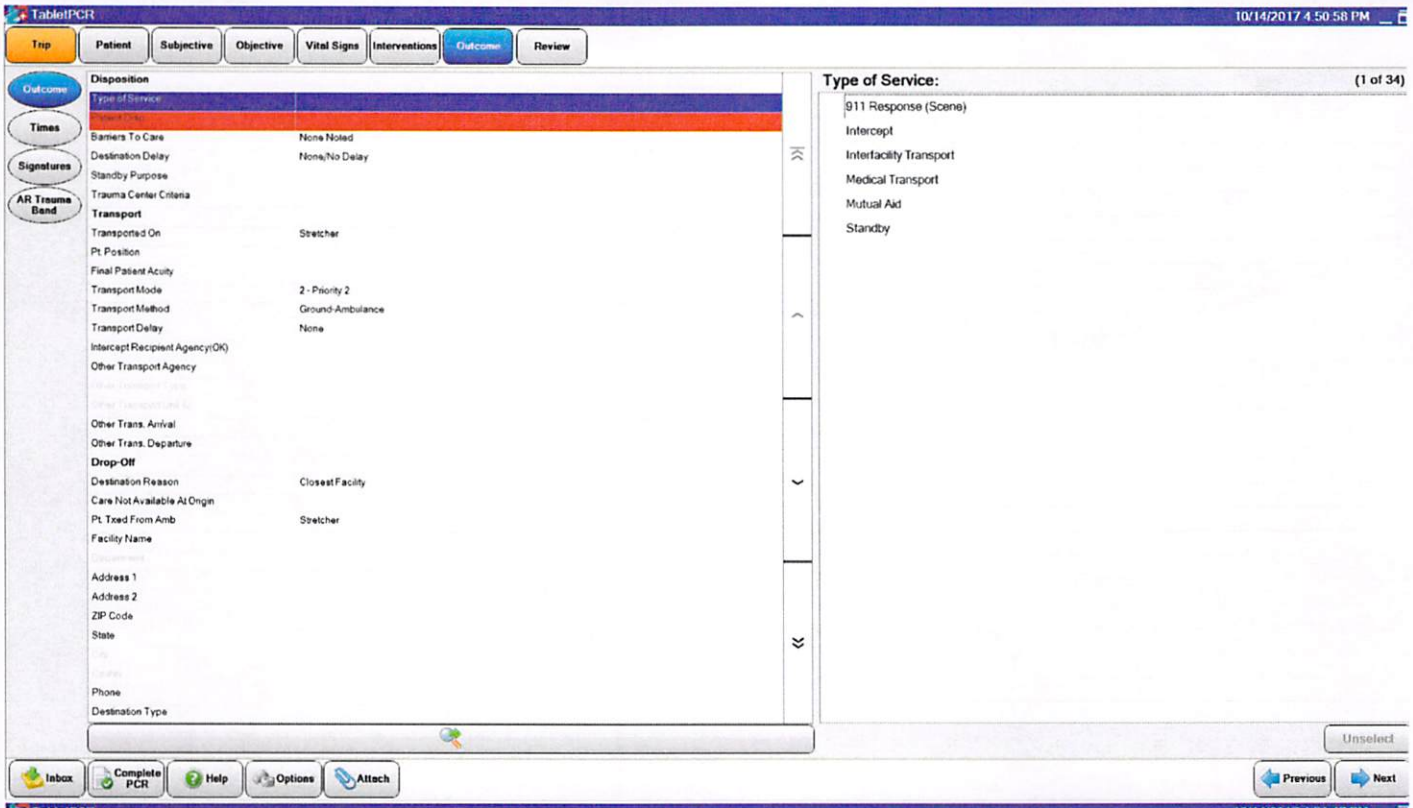
Add a state back in the state field and this will give the ability for data removal of any address fields below the state.

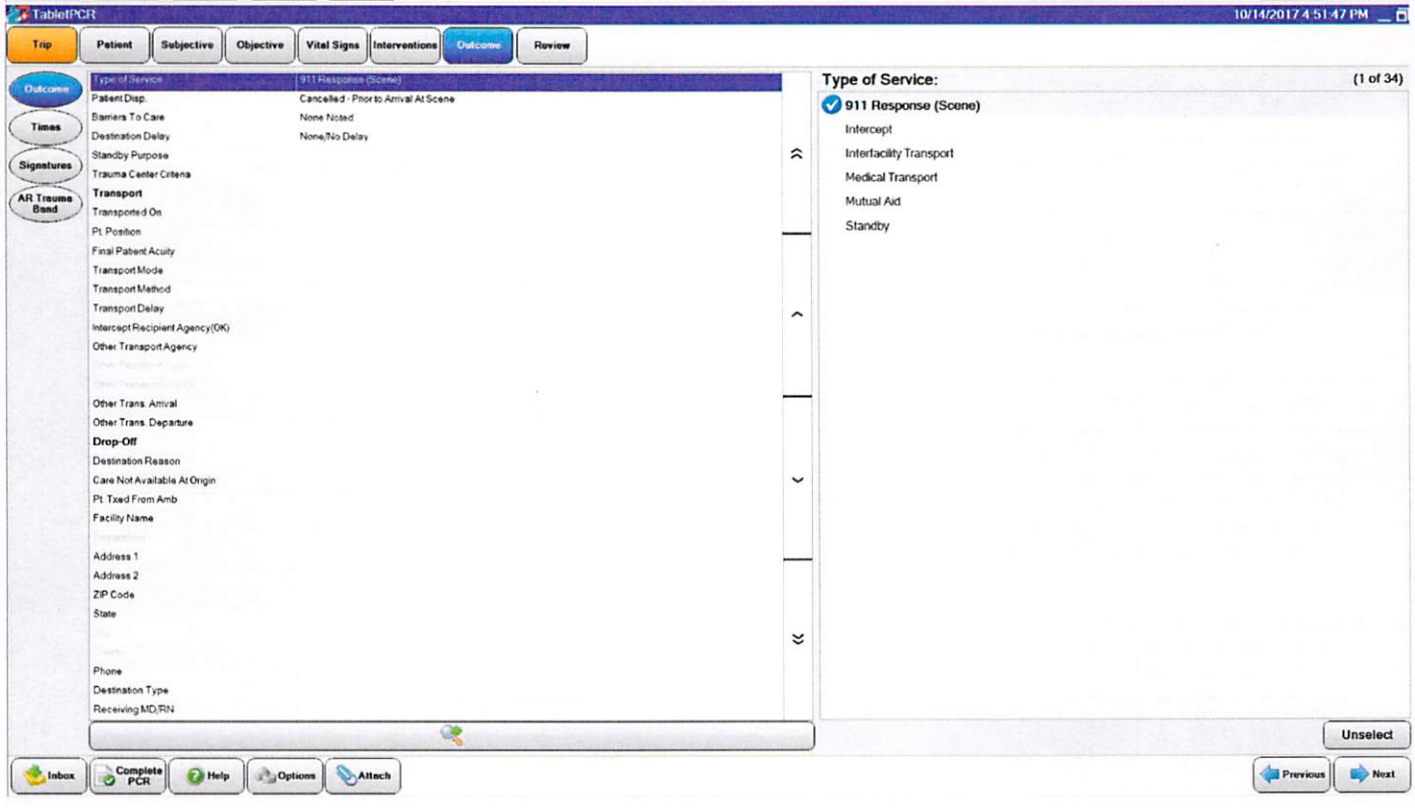


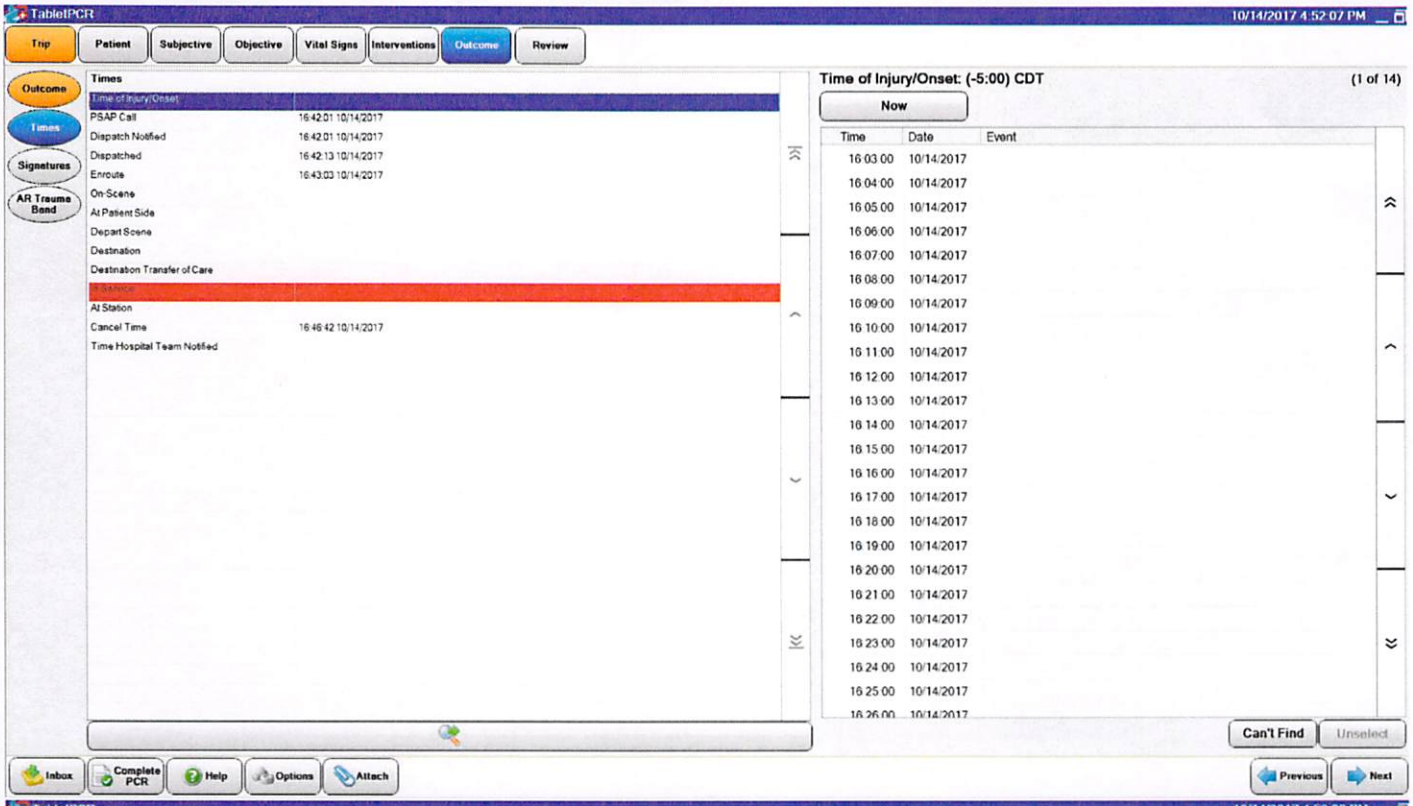
Canceled call Instructions

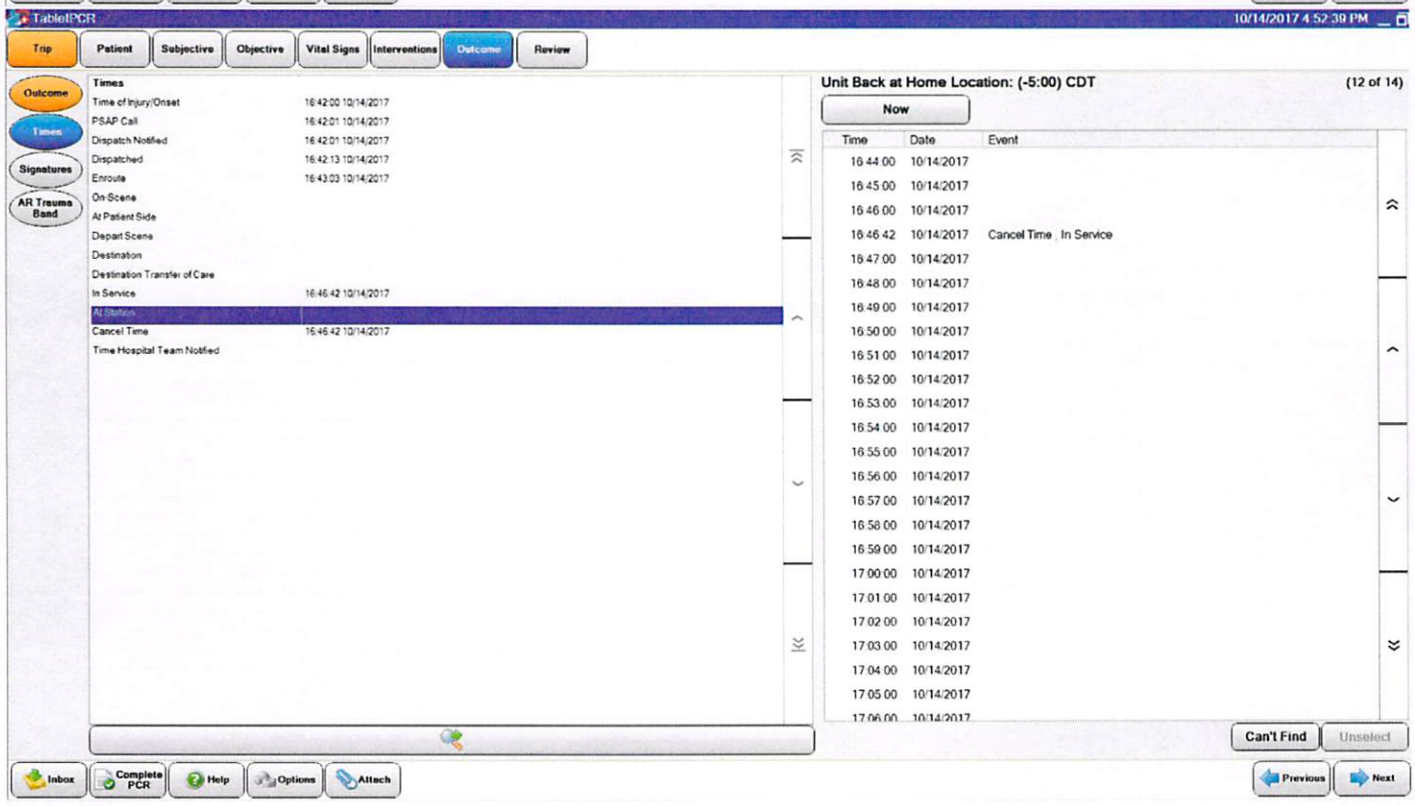
EPCR entry for clearing out cancelled calls

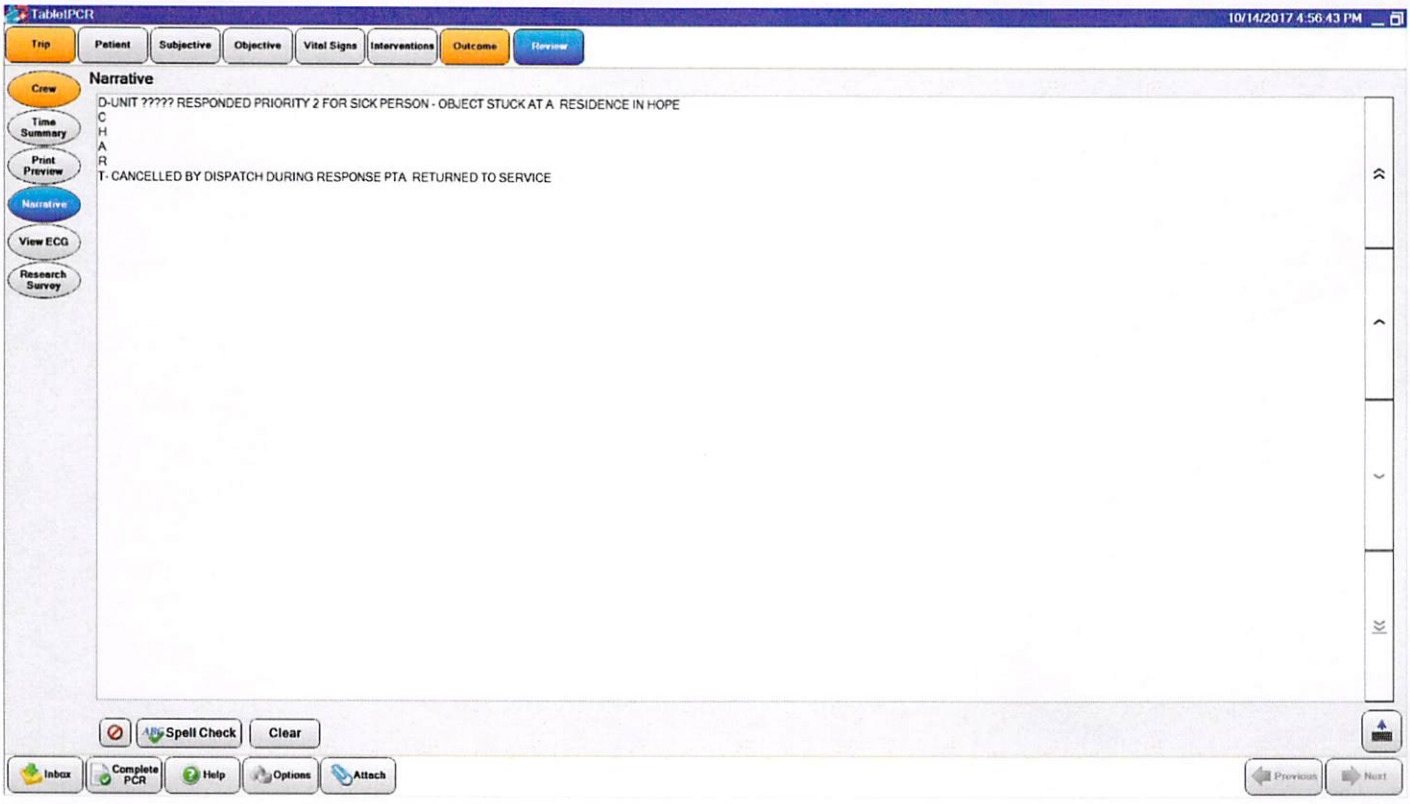



TabletPCR
10/14/2017 4:50:58 PM
Trip
Patient
Subjective
Objective
Vital Signs
Interventions
Outcome
Review
Outcome
Times
Signatures
AR Trauma Band
Disposition
Type of Service
Patient Disp.
Barriers To Care
None Noted
Destination Delay
None/No Delay
Standby Purpose
Trauma Center Criteria
Transport
Transported On
Stretcher
Pt. Position
Final Patient Acuity
Transport Mode
2 - Priority 2
Transport Method
Ground-Ambulance
Transport Delay
None
Intercept Recipient Agency(OK)
Other Transport Agency
Other Trans. Arrival
Other Trans. Departure
Drop-Off
Destination Reason
Closest Facility
Care Not Available At Origin
Pt. Txed From Amb
Stretcher
Facility Name
Address 1
Address 2
ZIP Code
State
Phone
Destination Type
Type of Service:
(1 of 34)
911 Response (Scene)
Intercept
Interfacility Transport
Medical Transport
Mutual Aid
Standby
Unselect
Inbox
Complete PCR
Help
Options
Attach
Previous
Next


TabletPCR
10/14/2017 4:51:47 PM
Trip
Patient
Subjective
Objective
Vital Signs
Interventions
Outcome
Review
Outcome
Times
Signatures
AR Trauma Band
Type of Service
911 Response (Scene)
Patient Disp.
Cancelled - Prior to Arrival At Scene
Barriers To Care
None Noted
Destination Delay
None/No Delay
Standby Purpose
Trauma Center Criteria
Transport
Transported On
Pt. Position
Final Patient Acuity
Transport Mode
Transport Method
Transport Delay
Intercept Recipient Agency(OK)
Other Transport Agency
Other Trans. Arrival
Other Trans. Departure
Drop-Off
Destination Reason
Care Not Available At Origin
Pt. Txed From Amb
Facility Name
Address 1
Address 2
ZIP Code
State
Phone
Destination Type
Receiving MD/RN
Type of Service:
(1 of 34)
911 Response (Scene)
Intercept
Interfacility Transport
Medical Transport
Mutual Aid
Standby
Unselect
Inbox
Complete PCR
Help
Options
Attach
Previous
Next


TabletPCR
10/14/2017 4:52:07 PM
Trip
Patient
Subjective
Objective
Vital Signs
Interventions
Outcome
Review
Outcome
Times
Signatures
AR Trauma Band
Times
Time of Injury/Onset
PSAP Call 16:42:01 10/14/2017
Dispatch Notified 16:42:01 10/14/2017
Dispatched 16:42:13 10/14/2017
Enroute 16:43:03 10/14/2017
On Scene
At Patient Side
Depart Scene
Destination
Destination Transfer of Care
In Service
At Station
Cancel Time 16:46:42 10/14/2017
Time Hospital Team Notified
Time of Injury/Onset: (-5:00) CDT
(1 of 14)
Now
Time
Date
Event
16:03:00 10/14/2017
16:04:00 10/14/2017
16:05:00 10/14/2017
16:06:00 10/14/2017
16:07:00 10/14/2017
16:08:00 10/14/2017
16:09:00 10/14/2017
16:10:00 10/14/2017
16:11:00 10/14/2017
16:12:00 10/14/2017
16:13:00 10/14/2017
16:14:00 10/14/2017
16:15:00 10/14/2017
16:16:00 10/14/2017
16:17:00 10/14/2017
16:18:00 10/14/2017
16:19:00 10/14/2017
16:20:00 10/14/2017
16:21:00 10/14/2017
16:22:00 10/14/2017
16:23:00 10/14/2017
16:24:00 10/14/2017
16:25:00 10/14/2017
Can't Find
Unselect
Inbox
Complete PCR
Help
Options
Attach
Previous
Next


TabletPCR
10/14/2017 4:52:39 PM
Trip
Patient
Subjective
Objective
Vital Signs
Interventions
Outcome
Review
Outcome
Times
Signatures
AR Trauma Band
Times
Time of Injury/Onset 16:42:00 10/14/2017
PSAP Call 16:42:01 10/14/2017
Dispatch Notified 16:42:01 10/14/2017
Dispatched 16:42:13 10/14/2017
Enroute 16:43:03 10/14/2017
On Scene
At Patient Side
Depart Scene
Destination
Destination Transfer of Care
In Service 16:46:42 10/14/2017
At Station
Cancel Time 16:46:42 10/14/2017
Time Hospital Team Notified
Unit Back at Home Location: (-5:00) CDT
(12 of 14)
Now
Time
Date
Event
16:44:00 10/14/2017
16:45:00 10/14/2017
16:46:00 10/14/2017
16:46:42 10/14/2017 Cancel Time : In Service
16:47:00 10/14/2017
16:48:00 10/14/2017
16:49:00 10/14/2017
16:50:00 10/14/2017
16:51:00 10/14/2017
16:52:00 10/14/2017
16:53:00 10/14/2017
16:54:00 10/14/2017
16:55:00 10/14/2017
16:56:00 10/14/2017
16:57:00 10/14/2017
16:58:00 10/14/2017
16:59:00 10/14/2017
17:00:00 10/14/2017
17:01:00 10/14/2017
17:02:00 10/14/2017
17:03:00 10/14/2017
17:04:00 10/14/2017
17:05:00 10/14/2017
Can't Find
Unselect
Inbox
Complete PCR
Help
Options
Attach
Previous
Next


TabletPCR
10/14/2017 4:56:43 PM
Trip
Patient
Subjective
Objective
Vital Signs
Interventions
Outcome
Review
Crew
Time Summary
Print Preview
Narrative
View ECG
Research Survey
Narrative
D-UNIT ????? RESPONDED PRIORITY 2 FOR SICK PERSON - OBJECT STUCK AT A RESIDENCE IN HOPE
C
H
A
R
T- CANCELLED BY DISPATCH DURING RESPONSE PTA RETURNED TO SERVICE
Spell Check
Clear
Inbox
Complete PCR
Help
Options
Attach
Previous
Next

In any instance that you are having trouble finishing out an EPCR we are here to help. Do have questions or suggestions we would like to hear your feedback. Just visit the help desk at the site listed below.

Please remember to include the run number, verify the ticket is saved onto the server, and add as much additional information of the problem including screen shots or pictures if available to further assist you. This way we can easily assist you and the ticket is accessible at the Hope office.

http://helpdesk.paffordems.com

HELP DESK TEAM

ZOLL EPCR TEAM:
Joshua Whisenhunt
Leesa Johnson

IT TEAM:
Morgan Smith
Derek Keathley
Hunter Lee
Jared Thomas- Ridgeland Office

Thank you