CRITICAL CARE TRANSPORTATION JUSTIFICATION FORM

This form **MUST** be **completed** and **signed** prior to any Inter-Facility Critical Care Transport is arranged.
Please fax completed form directly to 800-395-2953.

Transport Data

Patient Name _____ Date of Birth _____

Insurance Provider _____ Member ID _____

Referring Hospital _____ Receiving Hospital _____

Referring Provider _____ Receiving Provider _____

Transport Justification Data

A. Transport Mode (One MUST be checked in this section) ☐ Helicopter ☐ Mobile ICU

B. The receiving hospital has the following clinical services available at their facility that we are unable to provide at the time of the transport. (Check all that apply, one MUST be checked in this section)

☐ Subspecialty intervention for a multi-system trauma
☐ Subspecialty intervention for an orthopedic injury
☐ Specialized pediatric care for a pediatric injury/illness
☐ Obstetrical services not available at sending facility
☐ Hyperbaric treatment for toxic exposure or other emergent condition
☐ Level III nursery care for a neonatal emergency
☐ Sepsis
☐ Subspecialty intervention for vascular emergency
☐ Diagnostic or intervention for a neurological or neurosurgical injury or impairment
☐ Specialist for a gastro- intestinal injury or disease
☐ Transplant services not available at sending facility
☐ Reimplantation team for extremity injury
☐ Burn center care for thermal, chemical or electrical injuries
☐ Invasive diagnostics/intervention for a cardio thoracic injury or disease
☐ Other (PLEASE DESCRIBE): _____

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

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

D. Air transport is required to: (Check all that apply, one MUST be checked in this section)

☐ Critical care medications being infused/titrated (IE: vasopressors, <6 hours post TNKase)
☐ Significant concern for clinical deterioration
☐ Provide immediate surgical/procedural intervention
☐ Minimize out-of-hospital time

Provide details: _____

Certification Signature

I certify I have completed this report based upon the information available to me at the time of the patient's examination.

_____ _____
Certifying Practitioner Signature — Certifying Practitioner Name and Title Legibly Printed

_____ _____
Certifying Practitioner National Provider Identifier (NPI) — Date

Title of person signing: ☐ Attending Physician ☐ Physician Assistant ☐ Nurse Practitioner