Reason for Air Medical Transport: Scene

Air Ambulance Transport Provided By: _____

Call #: _____ **DOS:** _____

Patient Name: _____ **DOB:** _____

Reason for Transport/Chief Complaint necessitating or contributing to transfer: _____

_____

Reason for Air Ambulance Utilization

Requesting EMS Agency/First Responder: _____

Transport Destination: _____

Is this the Closest Facility with the CAPACITY and CAPABILITY required by this patient? ☐ YES ☐ NO

Was any other facility bypassed? ☐ YES ☐ NO

If so, why?: ☐ bed not available ☐ specialist not available ☐ weather/natural disaster/road conditions ☐ traffic

☐ multiple specialties required ☐ destination by protocol (specify):_____

☐ Other _____

Does the patient require immediate and rapid transport to the Accepting Facility that could not be provided by ground ambulance? Y/N_. If yes, why (Check all that apply)

- ☐ The time or instability of transportation by ground threatens the Patient's health or survival
- ☐ The distance to the closest appropriate facility would take more than 30 minutes by ground ambulance
- ☐ State or Regional Protocol
- ☐ Obstacles (such as heavy traffic) preclude transportation by ground ambulance
  Specify: _____
- ☐ The Scene is inaccessible by ground ambulance
- ☐ Patient requires critical or specialty care capabilities and/or personnel unavailable from local ground EMS resources

I certify, to the best of my knowledge and professional ability, that I have ordered air ambulance transportation because this patient's condition requires such transportation for the reasons set forth above, and transportation by ground ambulance is contraindicated. By so certifying, I am NOT assuming any financial responsibility for these air ambulance services.

Signature/Title: _____ **Date/Time**: _____

Does the requesting EMS Agency have a financial/employment relationship with Global Medical Response or subsidiaries? ☐ Yes ☐ No