

PATIENT'S NAME _____

WE ARE TRANSPORTING A (AGE) _____ YEAR OLD (RACE) _____ (SEX) M-F

CHIEF COMPLAINT/MECHANISM OF INJURY _____

PAST HISTORY _____

ALLERGIES _____

MEDICATIONS _____

LOC (A-V-P-U) ORIENTED TIMES _____ (Person-Place-Time)

PULSE RATE _____ QUALITY _____ EKG _____ B/P _____

RESPIRATIONS RATE _____ LUNG SOUNDS (L) _____ (R) _____

OXYGEN SATS _____ % PUPILS _____ PMS (UPPER) _____ (LOWER) _____

SKIN (COLOR) _____ (TEMP) _____ (MOIST) _____

OUR PHYSICAL EXAM REVEALS _____

TREATMENT (OXYGEN, IV'S, SPLINTS, IMMOBILIZATION, MEDICATIONS, ETC.) _____

PATIENTS DOCTOR IS _____ ETA IS _____ MINUTES

DO YOU HAVE ANY QUESTIONS OR ORDERS?

S igns/Symptoms	What do you see and hear?
A llergies	Are you allergic to anything?
M edications	Do you take any medications everyday?
P ast History	Has anything like this happened before?
L ast Intake	When did you last eat or drink?
E vents	What were you doing when this started?
O nset	When did this pain start?
P rovocation	Does anything make it better or worse?
Q uality	Can you describe the pain to me?
R elief/radiation	Does it hurt anywhere else?
S everity	Can you rate your pain on a scale of 1-10?
T ime	Have you ever had pain like this before?

EMS MEDICAL NECESSITY FORM

REVISED 2/2008

Transport Date _____

Patient Name _____

Loaded Miles _____

LOADED ODOMETER start _____

LOADED ODOMETER end _____

Chief Complaint _____

Assessment performed by _____ EMT

____ ALS Certified ____ BLS Certified

Name of ALS intercepting service (if applicable) _____

Point of Pickup: _____ Zip Code _____
____ Patient's Home ____ Skilled Nursing Facility ____ Hospital ____ Nursing Home ____ Other

Destination: _____
____ Patient's Home ____ Skilled Nursing Facility ____ Hospital ____ Nursing Home ____ Other

If you transported more than one patient, name(s) _____

Was patient discharged from the first hospital and admitted to the second hospital? Yes _____ No _____

Reason patient is being transferred: Bed Availability

Specialist What kind _____ Testing /Equipment What kind _____

PRIVACY AWARENESS

Wood River Rescue Unit has a HIPAA Notice of Privacy Practices. My signature affirms that Wood River Rescue Unit has offered me a written copy of their privacy policy.

REFUSED PRIVACY POLICY

RELEASE OF PAYMENT

I request that payment of authorized Medicare/State Medicaid/Blue Cross/Third Party/Automobile/Workers' Compensation/ Liability insurance and my Medigap benefits be made on my behalf to Wood River Rescue Unit for any services furnished me by that provider, now or in the future. I agree to immediately remit to Wood River Rescue Unit any payments that I receive directly from any source for the services provided to me and I assign all rights to such payments to Wood River Rescue Unit. I understand that I am financially responsible for the services provided to me by Wood River Rescue Unit, regardless of my insurance coverage and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I authorize Wood River Rescue Unit to appeal payment denials or other adverse decisions on my behalf without further authorization.

RELEASE OF MEDICAL / BILLING INFORMATION

I authorize and direct any holder of medical information or documentation about me to release such information to the Wood River Rescue Unit and its billing agents, and/or the Centers for Medicare and Medicaid Services and its MAC and agents, and/or any other payors or insurers as may be necessary to determine these or other benefits payable for any services provided to me by Wood River Rescue Unit, now or in the future. This is a lifetime authorization for any services provided to me by Wood River Rescue Unit. A copy of this form shall be the same force and effect as an original.

X Patient's Signature: _____ Date: _____

IF PATIENT IS UNABLE TO SIGN ABOVE DUE TO PHYSICAL OR MENTAL INABILITY, signature of Authorized Signer:

**Signing on behalf of the patient does not make me financially responsible for these services.*

*Signature: _____
 Spouse Blood Relative _____ (RELATIONSHIP) Legal Guardian Originating Facility POA Other _____

Reason patient could not sign _____ Date: _____

FOR EMERGENCY TRANSPORTS ONLY: *Signing on behalf of the patient does not make me financially responsible for these services.

I was a crew member on this trip and this patient was transported to the above named facility on this date _____ and time _____.

Patient was unable to sign for the following reason _____ and no "AUTHORIZED SIGNER" was available at the time of transport.

*EMT SIGNATURE _____

As a representative of the receiving facility, I certify the patient was received by our facility on the date and time above.

*RECEIVING FACILITY SIGNATURE _____ Title: _____