



LIFE FLIGHT/MOBILE LIFE CERTIFICATION OF TRANSPORT

PATIENT NAME: _____ Date: _____
 REFERRING PHYSICIAN: _____
 REFERRING HOSPITAL: _____
 DIAGNOSIS: _____
 DESTINATION: _____

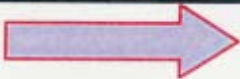
1

REASON FOR TX	*TRANSFER TO ANOTHER FACILITY IS NECESSARY DUE TO THE FOLLOWING SPECIALIZED SERVICE NOT AVAILABLE AT REFERRING HOSPITAL: (please check all that apply)	
	<input type="checkbox"/> Level VII trauma care.	<input type="checkbox"/> High risk obstetrical/neonatal services
	<input type="checkbox"/> Tertiary level cardiac critical care	<input type="checkbox"/> Tertiary respiratory critical care
	<input type="checkbox"/> Tertiary level vascular surgery	<input type="checkbox"/> Pediatric intensive care
	<input type="checkbox"/> Neurology/neurosurgery	<input type="checkbox"/> Tertiary Medical/Surgical Intensive Care
	<input type="checkbox"/> OTHER _____	

SECTIONS 1 & 2 NEED TO BE COMPLETED BY THE REFERRING PHYSICIAN OR REFERRING RN

2

MODE OF TRANSPORT	This patient is discharged from this hospital and is to be transported to the above noted receiving facility by:	
	MOBILE INTENSIVE CARE UNIT (MICU) due to: (please check below)	
	<input type="checkbox"/> Patient has potentially life/limb threatening injuries and requires critical care transport to a trauma center	
	<input type="checkbox"/> Level of care is critical. Patient's acuity is such that the continued assessment and interventions of a transport RN may be required to prevent complications and/or death.	
	Other: _____	
	LIFE FLIGHT HELICOPTER due to: (please check below)	
	<input type="checkbox"/> TIME FACTOR IS CRITICAL. Patient requires immediate treatment at a tertiary care center and may potentially be compromised by ground transport.	
	<input type="checkbox"/> Level of Care is Critical. Patient's acuity is such that the continued assessment and interventions of a physician and/or RN may be required to prevent complications and/or death. Transport by any other means may compromise the patient.	
	<input type="checkbox"/> OTHER _____	



X _____
 PHYSICIAN SIGNATURE OR V/O WITH REF. RN SIGNATURE

3

SECTION 3 NEEDS TO BE COMPLETED BY THE REFERRING RN, PATIENT AND/OR PATIENT'S FAMILY

Authorization for Treatment & Billing & Release of Information
 Please read and sign where indicated:

EXAMINATION & TREATMENT
 I agree to be examined by the staff of St. Vincent Mercy Medical Center (SVMMC), University of Toledo Medical Center (UTMC), and/or St. Rita's Medical Center (SRMC) Critical Care Transport Network, and further authorize such medical/surgical treatment and transportation per the Life Flight/Mobile Life staff and/or as advised by the Medical Control physician. I also authorize examination and treatment at the receiving hospital to which I am being transported. X _____ (initial)

BILLING & PAYMENT
 I hereby authorize SVMMC, UTMC, or SRMC Life Flight/Mobile Life to release information related to this transport to my referring physician or referring health care agency, pertinent government agency, insurance agency or health benefit plan, via SVMMC, UTMC, and/or SRMC Critical Care Transport Network now and in the future. I authorize payment by my auto insurance agency, health agency, government agency, insurance agency or health benefit plan to SVMMC, UTMC or SRMC for services provided by SVMMC, UTMC, and/or SRMC Critical Care Transport Network now and in the future. X _____ (initial)

RELEASE OF INFORMATION
 I authorize and consent to the release of medical information to emergency providers, physicians, and/or nurses, or health care agencies who have provided emergency or medical care to me prior to or following this transport for the treatment of my current illness or injury. X _____ (initial)

X _____ X _____
 Signature of Patient or Responsible Party Relationship to Patient (if responsible party)

Unable to obtain signature:
 Patient acuity precludes obtaining signature Patient physically unable to sign and no family present
 Other _____

X _____
 Referring Employee Signature Job Title

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)
 I hereby acknowledge receipt of the Mercy Health Partners Privacy Practices.

X _____ X _____ X _____
 Patient Name (PRINTED) Patient Signature Date

If form is signed by a personal representative, please indicate relationship to patient: _____