VITAL LINK

1033 EMS Dr.
Batesville, AR 72501
Business Office: 870-793-3351
Fax: 870-793-3159
Dispatch: 870-793-5708

Physician Certification Statement (PCS)

(CMS requires PCS for each non-emergency transfer)

Date of Service:_____
Patient Name:_____
SS#:_____ DOB:_____

Reason for Hospital Transfer: This patient is being transferred to:_____ for a **higher level of care** and to be seen by: Dr._____, whose specialty:_____ is not available locally on this day at this time. (complete only for hospital to hospital transfers)

AND/OR

Medical Necessity Description: This patient requires transportation by **ambulance** because they have medical condition(s) that require continuous care by medically trained personnel (Medics) and/or that make any other form of care and transportation inadvisable. Today, this patient's pertinent medical conditions include:

- ☐ Confusion/Disorientation
- ☐ Seizure precautions or medications
- ☐ Decreased level of consciousness
- ☐ Decubitus Ulcers or Wound Precaution
- ☐ Requires isolation precautions
- ☐ Risk of falling out of wheelchair
- ☐ Other_____
- ☐ Requires continuous oxygen
- ☐ Requires airway management or suctioning
- ☐ Requires cardiac monitoring
- ☐ Requires restraints
- ☐ Ventilator dependent
- ☐ IV Fluids and/or Medications Required
- ☐ Other_____

AND/OR

This patient requires transportation by **ambulance** today because he/she is unable to get up from bed without assistance, to ambulate, or to sit in a chair during transport due to:

- ☐ Contractures of extremities
- ☐ Gait instability, fall risk
- ☐ Can not stand, pivot, or ambulate
- ☐ Non weight bearing/immobilization
- ☐ Paralysis/Hemiparalysis/Hemiparesis
- ☐ Other _____

PCS must be signed by the treating or family physician or by a Physician's Assistant, Nurse Practitioner, RN, or discharge planner employed by the sending hospital or facility. (CMS states – an LPN may sign only if a discharge planner)

*Physician/Signer's Name (Print Legibly):*_____ Title:_____

Signature:_____ Date:_____

For Vital Link Use Only: Pt Name:_____DOB:_____

Clinical staff (answer these questions for each PCS form):

- ☐ PCS prepared & signed prior to patient contact ☐ PCS prepared by medic
- ☐ PCS matches assessment ☐ PCS does not match assessment, describe:_____
- ☐ Unable to obtain required signature due to:_____

Patient Accounts (record if PCS not obtained by clinical staff): Dates PCS Sent/Faxed: 1)_____ 2)_____

- ☐ Not Received ☐ Received Date:_____ (Retain copy for patient record)