



CERTIFICATE OF MEDICAL NECESSITY
Nursing Home Non-Emergency and
Emergency Ambulance Transport

Date of Transport: _____

Patient Name: _____ Soonercare # _____

Origin: _____ Destination _____

1. What medical Condition exists that makes transport by ambulance necessary?

2. Please check any or all of the following that apply. _____

_____ This patient is unconscious and/or unresponsive to voice/pain.

_____ This patient requires administration of medical care and/or assessment transport. (Cardiac monitoring, Medication administration, O2, etc.)

during

_____ This patient must be transported on a stretcher and may not be transported in a sitting position such as a wheelchair.

Please state why: _____

_____ This patient has a contagious disease. Please state DX. _____

_____ This patient requires restraint and/or constant attendance due to confusion or combativeness.

I certify to the best of my professional ability that this patient's condition warrants ambulance transportation and no lesser means is medically appropriate.

Print Physician Name: _____

Physician Signature: _____ Date: _____