OSF LIFE FLIGHT



855-OSF-FLYT

855-673-3598

osflifeflight.org

Patient Name:_____

Date:_____

Transfer Checklist

- ☐ *CERTIFICATE OF MEDICAL NECESSITY FOR AIR AMBULANCE (FORM ENCLOSED)*
- ☐ *CT SCANS X-RAYS ON CD (IF NOT AN OSF INTER-FACILITY TRANSFER)*
- ☐ *LAB RESULTS*
- ☐ *COPY OF CHART*
- ☐ *FACE SHEET*
- ☐ *HISTORY AND PHYSICAL OR ER SUMMARY*

OSF HEALTHCARE

H0060-70470-09-2018 (07/21)