OSF HEALTHCARE

855-OSF-FLYT
855-673-3598

OSF LIFE FLIGHT

# CERTIFICATE OF MEDICAL NECESSITY (CMN) FOR AIR AMBULANCE

## SECTION I TRANSPORT INFORMATION

Transport Number: _____

Patient Name: _____ Date of Service: _____

Transported From: _____ Transported To: _____

Sending Physician: _____ Receiving Physician: _____

Sending MRN#: _____ Receiving MRN# _____

## SECTION II REASON FOR MEDICALLY NECESSARY AIR TRANSPORT

☐ **Transportation by any mode other than by Air Ambulance is contraindicated due to the patient's clinical condition at time of transport:**

( ) Time Sensitive Intervention Required for the following Clinical Condition:

Cardiac_____Neuro_____OB/GYN_____NICU_____PICU_____

Trauma_____Burns_____Respiratory_____Unconscious/Shock_____

Severe Hemorrhage, Uncontrolled Bleeding_____

( ) Duration of ground transport would be excessive & potentially detrimental to the patient's outcome (greater than 30 to 60 minutes)

( ) Higher Level of Care required enroute than is immediately available by ground transport; EXPLAIN_____

( ) COUNTY / REGIONAL / STATE Protocols recommend Air Transport; EXPLAIN_____

( ) Obstacles or Conditions that would prolong or cause inaccessibility to the patient:

Weather _____ Environment _____Road /Traffic Conditions _____Disaster Situation _____

Closer Appropriate Facility on Bypass/Divert/Saturation_____Other_____

☐ **TRANSPLANT SURGICAL Intervention required for Organ Failure or Surgery;** EXPLAIN_____

☐ **Service not available at originating facility:**

( ) NICU / Pediatrics ( ) Advanced CardioPulmonary ( ) Advanced Neuro logical Services

( ) Certified Primary Stroke Care ( ) High-Risk OB

( ) Trauma/Burn Unit ( ) Orthopedics ( ) Other_____

☐ **Other** _____

☐ **EMTALA certified inter-facility transfer to capable appropriate facility and/or higher level of care**

*Pursuant to Federal COBRA / EMTALA Statute SEC. 1867. (42 U.S.C. 1395dd) (a) Social Security Act – medical Screening Requirement(s) – A patient cannot be transferred unless all of the following conditions have been met:*

***a**. The receiving facility has available space, qualified personnel, and the capacity to assume care of this patient;*

***b**. Copies of medical records referring to this patient incident will be provided to the receiving facility, if available;*

***c**. I hereby certify that the above listed diagnosis, condition(s), and/or physical obstacles to transfer this patient requires ambulance transport;*

***d**. Based on information and medical expertise available at the time of request for ambulance transport, it is my determination that the medical benefits reasonably expected from the provision of appropriate medical treatment at the receiving hospital outweigh the risks (if any) to the patient's condition.*

This Document may be Reviewed & Completed by: (Attending Physician, Physicians Asst, Nurse Practitioner, Clinical Nurse Specialist, Registered Nurse, or other authorized requestor)

**REFERRING PROVIDER SIGNATURE**_____ **DATE**_____

**PRINTED NAME & CREDENTIALS**_____

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