LIFE LINK III
FAX: 612-638-4970

PHYSICIAN ORDER FOR AIR AMBULANCE TRANSPORTATION

Patient Name ______________________ Date of Transport ______________________

Transported From ______________________ Transported To ______________________

Referring Physician ______________________ Receiving Physician ______________________

Reason for Air Transportation:

Non-availability of hospital services: ______________________

Non-availability of physician specialty(ies): ______________________

Receiving Facility Information:

Nearest facility capable of providing required level of care ______________________

☐ Family preference/request

☐ Physician preference/request

The Patient's Condition:

☐ Intracranial bleeding, requiring neurosurgical intervention

☐ Burns requiring treatment in a Burn Center

☐ Multiple severe injuries

☐ Cardiogenic shock

☐ Conditions requiring treatment in a Hyperbaric Oxygen Unit

☐ Life-threatening Trauma

☐ Other (please specify) ______________________

I certify that this information is true and correct based on my evaluation of the patient, to the best of my knowledge and professional training. I certify that air ambulance transportation is/was medically necessary for the above-named patient for the service date indicated. Transportation by ground ambulance in excess of thirty minutes would endanger the patient's health or life. I understand that this information will be used by the Department of Health and Human Services, Centers for Medicare and Medicaid Services, and/or its agents, to support the determination of medical necessity for air ambulance services.

Physician's Signature: ______________________ Date/Time: ______________________

Printed Physician Name: ______________________