Solano County
Interfacility Ambulance
Transfer Request Form

PATIENT IMPRINT

Instructions:
1. This form must be completed by the physician, it will help to identify what type of transport is required
2. Fax this completed form to the ambulance service provider and provide a hard copy to the transport team.
3. **ALS/ALS-RN transfers must be conducted by Medic Ambulance (Solano County EOA Provider) 707-644-8989**

Patient Diagnosis:_____ **Patient Allergies:**_____

Medicare/Medi-Cal Physician Certification Statement

The undersigned practitioner certifies that they have personal knowledge of the patient's condition at the time transport is ordered and is medically necessary as specified above. This is not a guarantee of coverage or payment. (Form may be signed by MD, DO, RN, CM, NP, NS, PA if Medicare. If **Medi-Cal**, form must be signed by Physician, i.e. MD, DO.)

_____

Signature **Date**

_____

Printed Name & Credentials **NPI Number**

Patient Condition: ☐**Critical** ☐**Noncritical**

☐ **BLS**	☐ **ALS (MUST GO TO EOA PROVIDER)**
☐ Supplemental oxygen Delivery type_____ Rate_____ Medical reason for O2_____ Reason unable to self-maintain O2_____ ☐ Isotonic IV solution @ TKO rate ☐ 5150 psychiatric hold ☐ Restraints ☐ Dementia requiring behavioral monitoring ☐ Isolation precautions ☐ Aspiration precautions ☐ Sedated, including narcotics within last 30 minutes ☐ Post-surgical positioning or movement precautions (fractures, decubitus ulcers, etc.) ☐ Bariatric patient: Weight:_____Height:_____ ☐ Other devices that require medical monitoring: Explain_____	☐ Paramedic level assessment & decision making ☐ IV solution <20 mEq/L of Potassium Chloride (KCL) ☐ Cardiac monitoring ☐ Standby external cardiac pacing ☐ Continuous positive airway pressure (CPAP) ☐ Nebulizer therapy ☐ One or more ALS medications: adenosine, aspirin, atropine, beta-2 agonist bronchodilators, calcium chloride, dextrose, diphenhydramine, epinephrine, fentanyl, glucagon, lidocaine, midazolam, morphine, naloxone, nitroglycerin tablets/spray, sodium bicarbonate
☐ ALS-RN (MUST GO TO EOA PROVIDER)	**☐ CCT**
☐ Nursing level assessment or decision making ☐ Medication(s) other than ALS medications listed above ☐ Medication(s) on an infusion pump ☐ Blood product infusion	☐ **Critically ill or injured** – requires physician's initials: _____ ☐ Ventilator management ☐ Invasive pressure monitoring devices (ex. CVP, Swan-Ganz, arterial line, ICP monitor, etc.) ☐ Transvenous pacing ☐ Intra-aortic balloon counter-pulsation device ☐ High-risk L&D that may lead to neonatal critical care ☐ Active titration of vasoactive agents (vasopressors) ☐ Neuromuscular blocking agents ☐ Continuous infusion of sedative agents (ex. propofol)

Requested response level: ☐ **STAT** ☐ **Scheduled (1-4 hrs)**
☐ **Immediate (60 min)** ☐ **Planned (4-72 hrs)**

Additional Doctor's Orders:

☐ PALS/ACLS/NRP protocols
☐ If patient needs services not available at sending facility, please specify: _____
☐ See attached order sheet for additional orders ☐ Other orders _____
EMS Time of Request_____ EMS Time of Arrival_____
Receiving Facility_____
Receiving Physician_____ Date and Time_____