



PATIENT TRANSPORT REPORT

PATIENT: LAST NAME		FIRST NAME	MI	DATE OF TRANSPORT	TRANSPORT NUMBER	UNIT NUMBER
HOME ADDRESS				PRIMARY PHYSICIAN	PHONE	
CITY	STATE	ZIP CODE		TIMES ARE RECORDED IN 24 HOUR MILITARY FORMAT		CREW CHIEF
TELEPHONE NUMBER				Dispatch: _____	Enroute: _____	DRIVER
SOCIAL SECURITY NUMBER				Arrive Scene: _____	Transpt: _____	OTHER
RACE	SEX	AGE	DATE OF BIRTH	Arrive Dest: _____	Avail: _____	
ORIGIN		ROOM		DESTINATION		ROOM
ADDRESS 1				ADDRESS 1		
CITY	STATE	ZIP CODE		CITY	STATE	ZIP CODE
PRIMARY INSURANCE				SECONDARY INSURANCE		MILEAGE ORIGIN
POLICY NUMBER		GROUP NUMBER		POLICY NUMBER		GROUP NUMBER
MILEAGE DESTINATION				MILEAGE DESTINATION		
MEDICARE NUMBER				DPA / PA ACCESS NUMBER		TOTAL MILEAGE

TRANSPORTATION

- ALS EMERGENCY
- ALS NON-EMERGENCY
- BLS EMERGENCY
- BLS NON-EMERGENCY
- CRITICAL CARE
- PARATRANSIT

CHIEF COMPLAINT		VITAL SIGNS		EQUIPMENT USED	
PAST MEDICAL HISTORY		TIME	TIME	<input type="checkbox"/> OXYGEN (LPM) _____ <input type="checkbox"/> CARDIAC MONITOR <input type="checkbox"/> 12 LEAD EKG <input type="checkbox"/> BAG VALVE MASK <input type="checkbox"/> VENTILATOR <input type="checkbox"/> IV PUMPS <input type="checkbox"/> CPAP <input type="checkbox"/> OTHER _____ <input type="checkbox"/> 2nd Crew / Lifting	
MEDICATIONS		B/P	B/P		
		PULSE	PULSE		
ALLERGIES		RESP	RESP		

MEDICAL NECESSITY INFORMATION

Patient Position at Origin <input type="checkbox"/> Laying <input type="checkbox"/> Sitting <input type="checkbox"/> Standing/Walking		Patient Position at Destination <input type="checkbox"/> Laying <input type="checkbox"/> Sitting <input type="checkbox"/> Standing/Walking		Moved to stretcher via	
Patient Found at Origin <input type="checkbox"/> Medical Bed <input type="checkbox"/> Geri-Chair <input type="checkbox"/> Chair <input type="checkbox"/> Standard Bed <input type="checkbox"/> Wheelchair <input type="checkbox"/> Other _____		Patient Left at Destination <input type="checkbox"/> Medical Bed <input type="checkbox"/> Geri-Chair <input type="checkbox"/> Chair <input type="checkbox"/> Standard Bed <input type="checkbox"/> Wheelchair <input type="checkbox"/> Other _____		<input type="checkbox"/> Sheet Pull <input type="checkbox"/> Slide Board <input type="checkbox"/> Hoyer-type Lift <input type="checkbox"/> Extremity Carry	
Patient Conditions (CHECK ALL THAT APPLY—MUST BE COMPLETED FOR EVERY PATIENT)					
<input type="checkbox"/> Unconscious / Unresponsive <input type="checkbox"/> Decreased Level of Consciousness <input type="checkbox"/> Patient cannot get up without assistance <input type="checkbox"/> Pt cannot ambulate <input type="checkbox"/> Pt cannot sit in a chair or wheelchair <input type="checkbox"/> Obese Weight		<u>Extremity Contractures</u> <input type="checkbox"/> Upper <input type="checkbox"/> Lower		<u>Upper Body Strength</u> <input type="checkbox"/> Yes <input type="checkbox"/> NO	
		<u>Decubitus Ulcers</u> <input type="checkbox"/> Sacral: Stage _____ <input type="checkbox"/> Buttocks: Stage _____		<u>Paralysis</u> <input type="checkbox"/> Yes <input type="checkbox"/> NO	
Who will be caring for patient at destination <input type="checkbox"/> Self <input type="checkbox"/> Home Care <input type="checkbox"/> RN <input type="checkbox"/> Hospice <input type="checkbox"/> Family <input type="checkbox"/> Other _____		<u>Sitting Restrictions (If Any)</u> <input type="checkbox"/> Immobilization Device <input type="checkbox"/> Elevated Legs / Hips <input type="checkbox"/> Limited Torso Bending <input type="checkbox"/> Pt Physical Condition			

OFFICE USE ONLY



PATIENT: LAST NAME	FIRST NAME	MI	DATE OF TRANSPORT
SENDING PHYSICIAN			TRANSPORT NUMBER

PATIENT TRANSPORT REPORT

NARRATIVE

DISPATCHED TO

HISTORY OF PRESENT ILLNESS

PHYSICAL EXAMINATION/ASSESSMENT

TREATMENT

DISPOSITION

DRIVER (PRINT)

CERT #

ATTENDANT (PRINT)

CERT #

DRIVER SIGNATURE

ATTENDANT SIGNATURE

BILLING AUTHORIZATION, RESPONSIBILITY FOR PAYMENT, ASSIGNMENT OF BENEFITS

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of STAT Medical Transport's Notice of Privacy Practices. A copy of this form is as valid as the original.

BILLING AUTHORIZATION, RESPONSIBILITY FOR PAYMENT AND ASSIGNMENT OF BENEFITS

I understand that I am financially responsible for the services provided to me by STAT Medical Transport, regardless of insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to this provider of ambulance service for any services furnished to me by this ambulance provider. I authorize and direct any holder of medical information or documentation about me to release to the Center for Medicare and Medical Services and its carriers and agents any information or documentation needed to determine these benefits or benefits payable for any service provided to me by this ambulance provider. I agree to immediately remit to this provider any payments that I receive directly from any source for the services provided to me and I assign all rights to such payments to this ambulance provider.

PATIENT SIGNATURE

PATIENT NAME (PRINT)

DATE

X

PATIENT UNABLE TO SIGN DUE TO:

REPRESENTATIVE SIGNATURE

REPRESENTATIVE NAME & RELATIONSHIP TO PATIENT

DATE

WITNESS SIGNATURE

WITNESS NAME (PRINT)

DATE

PATIENT CHART OR TRANSFER PAPERWORK CONFIRMATION

I acknowledge that I have received the transfer paperwork and/or patient chart from STAT Medical Transport, LLC.

FACILITY STAFF SIGNATURE

FACILITY STAFF (PRINT)

DATE



PATIENT TRANSPORT REPORT (Continuation / Addendum)

PATIENT: LAST NAME	FIRST NAME	MI	DATE OF TRANSPORT	TRANSPORT NUMBER	UNIT NUMBER
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NARRATIVE	VITAL SIGNS		
	TIME	TIME	TIME
	B/P	B/P	B/P
	PULSE	PULSE	PULSE
	RESP	RESP	RESP
	TIME	TIME	TIME
	B/P	B/P	B/P
	PULSE	PULSE	PULSE
	RESP	RESP	RESP
	TIME	TIME	TIME
	B/P	B/P	B/P
	PULSE	PULSE	PULSE
	RESP	RESP	RESP

DRIVER (PRINT)	CERT #	ATTENDANT (PRINT)	CERT #
DRIVER SIGNATURE		ATTENDANT SIGNATURE	