PATIENT TRANSPORT CHECKLIST

(place in envelope for flight crew)

COPIES OF THE FOLLOWING FOR:	LOM	RECEIVING HOSPITAL
Physician Certification of Medical Necessity		
Patient Consent (LifeFilght of Maine)		
Demographic / Face Sheet		
H & P / Discharge Summary		
Films / CDs		
EMTALA		
Advance Directives		
Labs (last 24 hours)		
Medication Records (last 24 hours)		
Nursing Assessment (optional)		
IF APPLICABLE:		
Emergency Room Record		
Consults		
OP Notes (optional)		
Social Work Notes (optional)		



LIFEFLIGHT OF MAINE

931 Union St. Bangor, ME 04401-0655 (207) 275-2920

PHYSICIAN CERTIFICATION OF MEDICAL NECESSITY

PATIENT NAME:	DATE:	
Interfacility Transport Requirements		
Based on an assessment of this patient, critical care tra	insport is required for the following reasons:	
(Mark ALL that apply, minimum of ONE per section)	risport is required for the following reasons.	
(man <u></u> mat appry)		
SECTION 1		
O Patient's condition cannot be managed at referring	g facility for the following reasons:	
O Diagnostic Testing or Evaluation not availab	le at referring	
□ Radiology □ Trauma	□ Surgical □ ICU □ Nephrology □ Transplant	
 Intervention not available at referring 		
□ Cardiac Catheterization □ Surgery	□ Interventional Radiology	
□ Dialysis □ Endoscopy	□ Hyperbaric Therapy	
Neonatal/Maternal specialty careOther, explain:		
Other, explain.		
SECTION 2 – Reasons for MODE of transport :		
Patient's condition is TIME CRITICAL		
Ground travel or time of ground travel may wo	rsen patient's condition	
No local EMS transport available		
Other, explain:		
SECTION 3 – Reason patient required Critical Care Tra	nsport Team from REFERRING:	
The patient is UNSTABLE		
	ransport team management of resuscitation	
 Requiring active management of medication of practice 	Requiring active management of medication administration or other interventions beyond scope of paramedic scope of parameters.	
•		
O Patient has HIGH RISK for INSTABILITY during t	ransport	
 Patient requires active management to ma 	, ,	
	, neurologic, cardiac or metabolic deterioration during transport requiring	
active management beyond paramedic sco		
□ Other Medical Condition:		
Referring HOSPITAL resources unavailable for tr	ansport	
increming most in its resources and valuable for a		
SECTION 4 – If patient is not being transferred to clos	sest appropriate facility:	
One beds or medical specialty available at closest hose	spital \bigcirc Patient's Clinician for ongoing care is at destination hospital	
\bigcirc Patient Preference (Patient has been advised of fina		
Other, explain:		
The undersigned (MD, DO, PA-C or NP) affirms that the	selected statements or comments above are accurate.	

SIGNATURE:

Clinician's NAME:

PATIENT CONSENT FORM

atient Name	RC#
esponsible for payment for this service including any laine by any applicable insurance or other benefit pegular charges for this medical transportation and training process. I give permission for LifeFlight of Marganization, and to other persons who may become a concerning my condition and treatment as reasonably by treatment for which they are obligated. My conservation about me in written or electronic form to a see extent reasonably required for quality review, reint and provisions listed CFR 45 164.520, the Health Information about me in the extent reasonably required for quality review, reint approximation and the review of the extent reasonably required for quality review, reint approximation to LifeFlight of Mai eleased, I can revoke all or part of this consent may ther adverse consequences. I understand that any refeatment, denial of health insurance or other benefits, and refuse disclosure of any part or all of the record. I payed a copy of this form on request.	at and transport rendered to me or my dependents by LifeFlight of Maine. I am ultimate deductible coinsurance or non-covered services. I request a direct payment to LifeFlight payor, medical benefits and other sums otherwise payable to me but not to exceed the eatment. I acknowledge that I have been given a copy of the notice of LifeFlight of Maine and its agents to disclose to any appropriate insurance carrier and its contracted revilegally obligated to pay all or part of my treatment and transportation bill any information to necessary to provide payors with enough information to allow them to pay for that part to this disclosure with respect to each payor will only expire upon final settlement of I give permission to LifeFlight of Maine and its agents to release financial, medical and of appropriate physicians, healthcare facilities, follow-up entities and prehospital providers inbursement and in order to assist me to secure continuity of care consistent with Maine I mation Privacy & Protection Act (HIPAA). I authorize any healthcare provider participating ine. This permission will expire in 30 months. To the extent information has not been alreaded in improper diagnosis or treatment, denial of health Insurance or other benefits, of the release information or revocation of this consent may result improper diagnosis, or other adverse consequences. I understand that I may review my record prior to release permit a copy of this authorization to be used in place of the original. I understand that I may review my record prior to release permit a copy of this authorization to be used in place of the original. I understand that I may review my record prior to release permit a copy of this authorization to be used in place of the original. I understand that I may review my record prior to release permit a copy of this authorization to be used in place of the original.
SECTION I – PATIENT SIGNATURE	SECTION II – AUTHORIZED REPRESENTATIVE SIGNATURE
The patient must sign here unless the patient is physically or mentally incapable of signing.	Complete this section only if the patient is physically or mentally incapable of signing Reason the patient is physically or mentally incapable of signing:
XPatient Signature or Mark Date If the patient signs with an "X" or other mark, someone should sign below as a witness. This can be a LifeFlight Crew member. XWitness Signature Date	Authorized representatives include only the following individuals (check one): Patient's Legal Guardian Patient's Health Care Power of Attorney Relative or other person who receives government benefits on behalf of patient Relative or other person who arranges treatment or handles the patient's affairs Representative of an agency or institution that furnished care, services or assistant to the patient. (May be obtained on back of this form) I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility for the services rendered.
Witness Printed Name	X Representative Signature Date Printed Name of Representative
NOTE: if the patient is a minor, the parent or legal guardian should sign in this section.	Representative's Address
SECTION III TIEFFIIGH	
Complete this section only if: (1) the patient was phywas available or willing to sign on behalf of the patient. A. LifeFlight of Maine Crew Member States. My signature below indicates that, at the time.	ment (must be completed by crew member at time of transport) e of service, the patient named above was physically or mentally incapable of signing, and sted in Section II of this form were available or willing to sign on the patient's behalf. My
Complete this section only if: (1) the patient was physwas available or willing to sign on behalf of the patient. A. LifeFlight of Maine Crew Member States. My signature below indicates that, at the time that none of the authorized representatives lissing at ure is not an acceptance of financial residue.	sically or mentally incapable of signing, and (2) no authorized representative (Section II) int at the time of service. ment (must be completed by crew member at time of transport) e of service, the patient named above was physically or mentally incapable of signing, and sted in Section II of this form were available or willing to sign on the patient's behalf. My
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Printed Name and Title of Receiving Facility Representative

financial responsibility for the services rendered to this patient.

Signature of Receiving Facility Representative