# PATIENT TRANSPORT CHECKLIST

*(place in envelope for flight crew)*

## Copies of the Following For:

<table>
<thead>
<tr>
<th>Medical Document</th>
<th>LOM</th>
<th>Receiving Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Certification of Medical Necessity</td>
<td></td>
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<tr>
<td>Patient Consent (LifeFlight of Maine)</td>
<td></td>
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<tr>
<td>Demographic / Face Sheet</td>
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<tr>
<td>H &amp; P / Discharge Summary</td>
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<tr>
<td>Films / CDs</td>
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<tr>
<td>EMTALA</td>
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<tr>
<td>Advance Directives</td>
<td></td>
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<tr>
<td>Labs (last 24 hours)</td>
<td></td>
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<tr>
<td>Medication Records (last 24 hours)</td>
<td></td>
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<tr>
<td>Nursing Assessment (optional)</td>
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</tbody>
</table>

## If Applicable:

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<tr>
<th>Medical Document</th>
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<tbody>
<tr>
<td>Emergency Room Record</td>
<td></td>
<td></td>
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<tr>
<td>Consults</td>
<td></td>
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<tr>
<td>OP Notes (optional)</td>
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<tr>
<td>Social Work Notes (optional)</td>
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</tbody>
</table>
Interfacility Transport Requirements

Based on an assessment of this patient, critical care transport is required for the following reasons:
(Mark ALL that apply, minimum of ONE per section)

SECTION 1

- Patient’s condition cannot be managed at referring facility for the following reasons:
  - Diagnostic Testing or Evaluation not available 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 care
  - Other, explain:

SECTION 2 – Reasons for MODE of transport:

- Patient’s condition is TIME CRITICAL
- Ground travel or time of ground travel may worsen patient’s condition
- No local EMS transport available
- Other, explain:

SECTION 3 – Reason patient required Critical Care Transport Team from REFERRING:

- The patient is UNSTABLE
  - Patient has ongoing need for critical care transport team management of resuscitation
  - Requiring active management of medication administration or other interventions beyond scope of paramedic scope of practice
  - Other Medical Condition:
  - Patient has HIGH RISK for INSTABILITY during transport
  - Patient requires active management to maintain stability during transport
  - Patient has high risk of airway/pulmonary, neurologic, cardiac or metabolic deterioration during transport requiring active management beyond paramedic scope of practice
  - Other Medical Condition:

- Referring HOSPITAL resources unavailable for transport

SECTION 4 – If patient is not being transferred to closest appropriate facility:

- No beds or medical specialty available at closest hospital
- Patient’s Clinician for ongoing care is at destination hospital
- Patient Preference (Patient has been advised of financial responsibility for transport)
- Other, explain:

The undersigned (MD, DO, PA-C or NP) affirms that the selected statements or comments above are accurate.

Clinician’s NAME: _______________________________ SIGNATURE: _______________________________

01/07/2016
PATIENT CONSENT FORM

I have been advised of and consented to all treatment and transport rendered to me or my dependents by LifeFlight of Maine. I am ultimately responsible for payment for this service including any deductible coinsurance or non-covered services. I request a direct payment to LifeFlight of Maine by any applicable insurance or other benefit payor, medical benefits and other sums otherwise payable to me but not to exceed their regular charges for this medical transportation and treatment. I acknowledge that I have been given a copy of the notice of LifeFlight of Maine privacy practices. I give permission for LifeFlight of Maine and its agents to disclose to any appropriate insurance carrier and its contracted review organization, and to other persons who may become legally obligated to pay all or part of my treatment and transportation bill any information concerning my condition and treatment as reasonably necessary to provide payors with enough information to allow them to pay for that part of my treatment for which they are obligated. My consent to this disclosure with respect to each payor will only expire upon final settlement of the amount due or after 30 months, whichever comes first. I give permission to LifeFlight of Maine and its agents to release financial, medical and other information about me in written or electronic form to appropriate physicians, healthcare facilities, follow-up entities and prehospital providers to the extent reasonably required for quality review, reimbursement and in order to assist me to secure continuity of care consistent with Maine law and provisions listed CFR 45 164.520, the Health Information Privacy & Protection Act (HIPAA). I authorize any healthcare provider participating in my care to release such information to LifeFlight of Maine. This permission will expire in 30 months. To the extent information has not been already released, I can revoke all or part of this consent may result in improper diagnosis or treatment, denial of health insurance or other benefits, or other adverse consequences. I understand that any refusal to release information or revocation of this consent may result improper diagnosis or treatment, denial of health insurance or other benefits, or other adverse consequences. I understand that I may review my record prior to release and refuse disclosure of any part or all of the record. I permit a copy of this authorization to be used in place of the original. I understand that I may

ONE of the following three sections MUST be completed

SECTION I – PATIENT SIGNATURE
The patient must sign here unless the patient is physically or mentally incapable of signing.

X Patient 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.

X Witness Signature Date

Witness Printed Name

NOTE: if the patient is a minor, the parent or legal guardian should sign in this section.

SECTION II – AUTHORIZED REPRESENTATIVE SIGNATURE
Complete this section only if the patient is physically or mentally incapable of signing.
Reason the patient is physically or mentally incapable of signing:

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 assistance 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.

X Representative Signature Date Printed Name of Representative

Representative’s Address

SECTION III – LIFEFLIGHT OF MAINE CREW AND RECEIVING FACILITY SIGNATURES
Complete this section only if: (1) the patient was physically or mentally incapable of signing, and (2) no authorized representative (Section II) was available or willing to sign on behalf of the patient at the time of service.

A. LifeFlight of Maine Crew Member Statement (must be completed by crew member at time of transport)

My signature below indicates that, at the time of service, the patient named above was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient’s behalf. My signature is not an acceptance of financial responsibility for the services rendered.

Reason patient incapable of signing: ________________________________ Time at Receiving Facility: ____________

Name and Location of Receiving Facility:

X Signature of Crewmember Date Printed Name of Crewmember

B. Receiving Facility Representative (A hospital form indicating ambulance transport may be used in lieu of signature)

The patient named on this form was received by this facility at the date and time indicated above. My signature is not an acceptance of financial responsibility for the services rendered to this patient.

X Signature of Receiving Facility Representative Date Printed Name and Title of Receiving Facility Representative

10/15/2015