HARTFORD HOSPITAL

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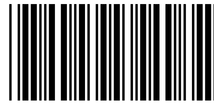

LIFE STAR TRANSPORT PHYSICIAN CERTIFICATION FORM

Patient Name ______________________________ Transport # __________ Date _______

From: ____________________________________ To: ________________________________

Requested by (name) _________________________ Vehicle # __________ Initials _____

General Criteria for Critical Care Transport: (must be completed on all transports)

- ❒ Required therapeutic regimen that must be initiated in a limited time frame.
- ❒ Safe and legal transfer requires critical care RN at a minimum.
- ❒ Land transport would be hazardous and delayed due to road and/or traffic conditions.
- ❒ Critical care / ALS environment required during transfer.
- ❒ Time of transfer between critical care units must be minimized.
- ❒ Complicated medical history requires transfer to patient's primary physician.
- ❒ Equipment and/or personnel to care for injury/illness not available at referring facility.
- ❒ Patient requires specialized interventions/test not available at referring facility.
- ❒ No other mode of transportation available.
- ❒ Other____

❒ **Medical Criteria**
Primary Diagnosis:____

Secondary Diagnosis:____

❒ **Surgical Criteria**
Primary Diagnosis:____

Secondary Diagnosis:____

❒ **Trauma Criteria**
Primary Diagnosis:____

Secondary Criteria:____

Comments: ____

Interfacility statement:

_____ In my professional opinion, critical care Air / Ground transport is required for this patient for the reasons indicated. I hereby order and consent to transport, under the care of the critical care transport team, utilizing current LIFE STAR transport guidelines, policies, clinical procedures and standards of care. Based on the information available at this time, the medical benefits reasonably expected from patient transfer outweigh the possible risks of patient transfer.

Prehospital Statement:

_____ LIFE STAR is requested to prehospital responses based on first responders judgement with regards to mechanism of injury / illness, anatomic, physiologic and situational factors. The criteria for this judgement are based in part on the trauma guidelines from the American College of Surgeons and the Connecticut State Trauma Regulations.

___________	______________________________	______________________________
Date	Physician Signature	Print Physician Name

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