



Patient Name: _____ Date: ____/____/____

From: _____ To: _____

PRESCRIPTION FOR AMBULANCE TRANSPORT

I hereby authorize the transport of _____ by ambulance.

Physician signature or Verbal Order (X) _____ **Date:** ____/____/____

The physician must complete the information. Clinical conditions which require the prescription for the means of transportation should be filled in.

- Patient was on continuous oxygen in the hospital for an acute condition or chronically and requires oxygen en route.
 - Patient must be immobile or supine because _____
 - Patient has an underlying condition which resulted in a bedridden status prior to hospitalization. Because of this condition, this individual does not ambulate nor sit up in the chair for any significant amount of time. Indicate the conditions: _____
 - Patient requires restraints either because of inability to cooperate or inability to safely sit because: _____
 - Patient has been aggressive or has had a behavioral problem in the past and requires restraints for safe transport.
 - Patient has significant decubiti, >3cm., in areas which prohibit being in a sitting position for 30 minutes or longer.
 - Patient is unable to be in a sitting position for 30 min. or longer. Because of the following condition, the patient can not sit for this period of time: _____
 - Patient experiences pain with ambulation or sitting more than 30 min. because of the following condition: _____
 - Patient was on strict bedrest in the hospital and will continue on such after transport because: _____
 - Hospital to hospital transport, indicate the equipment or facility or services not available at the facility: _____
- ALS service during transport, indicate the condition for which it is needed and the expertise needed enroute:
- Cardiac Monitoring
 - IV Therapy
 - Advanced Airway
 - Advanced Nurse Skill(s)
 - Other _____

CODE STATUS (PLEASE CIRCLE)

FULL CODE

DO NOT RESUSCITATE