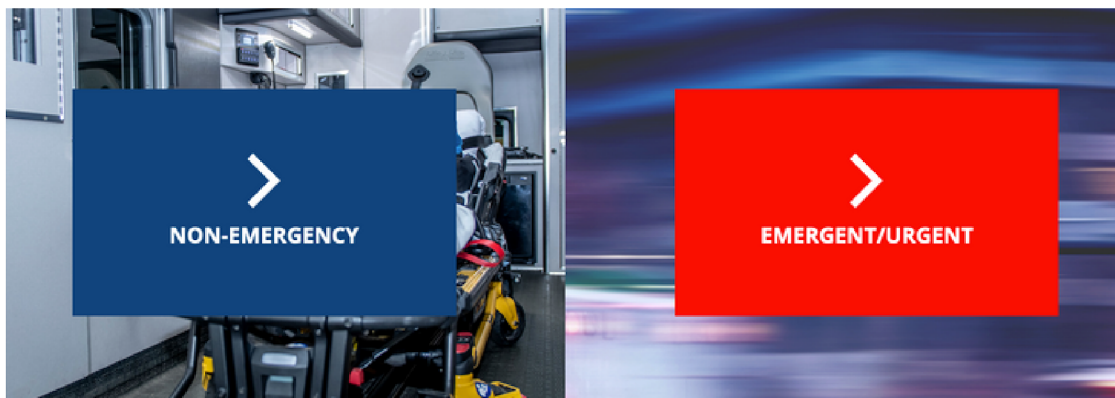


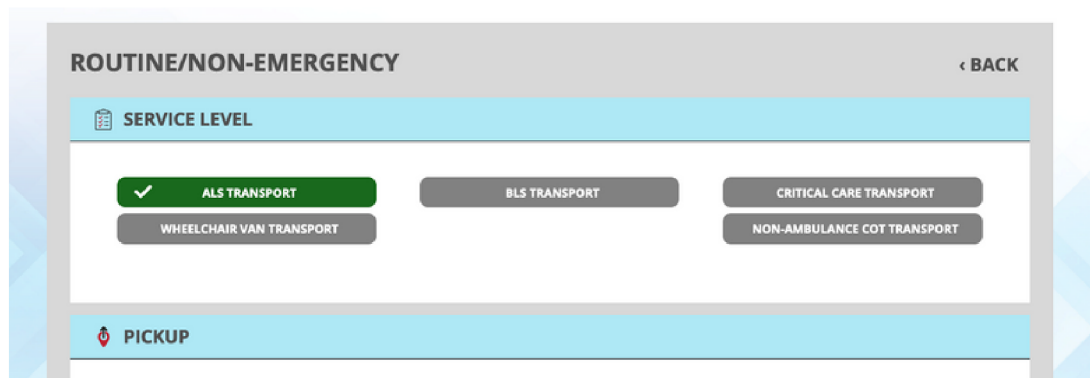
LOG IN TO STATCALL



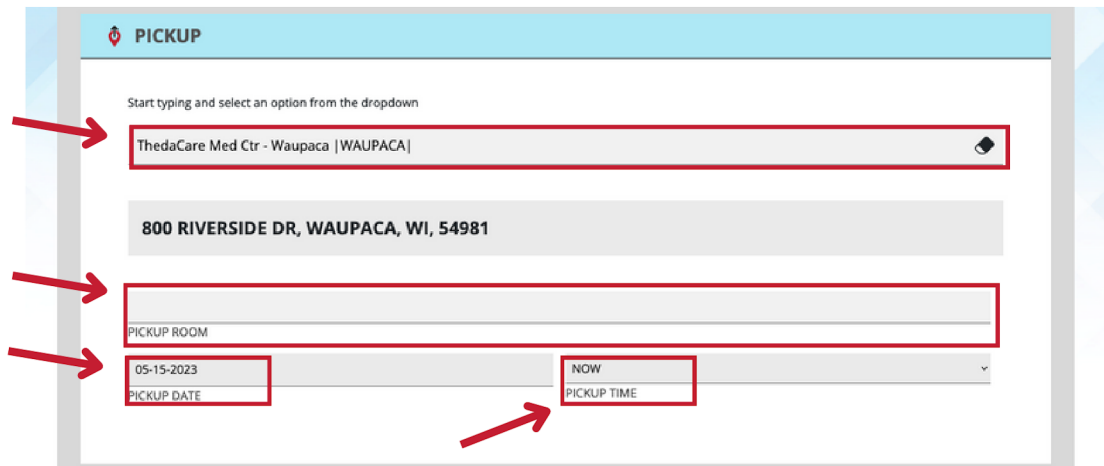
SELECT URGENCY



SELECT SERVICE LEVEL



SET PICKUP LOCATION, NOTE ROOM NUMBER, DATE, AND TIME



PICKUP

Start typing and select an option from the dropdown

ThedaCare Med Ctr - Waupaca | WAUPACA

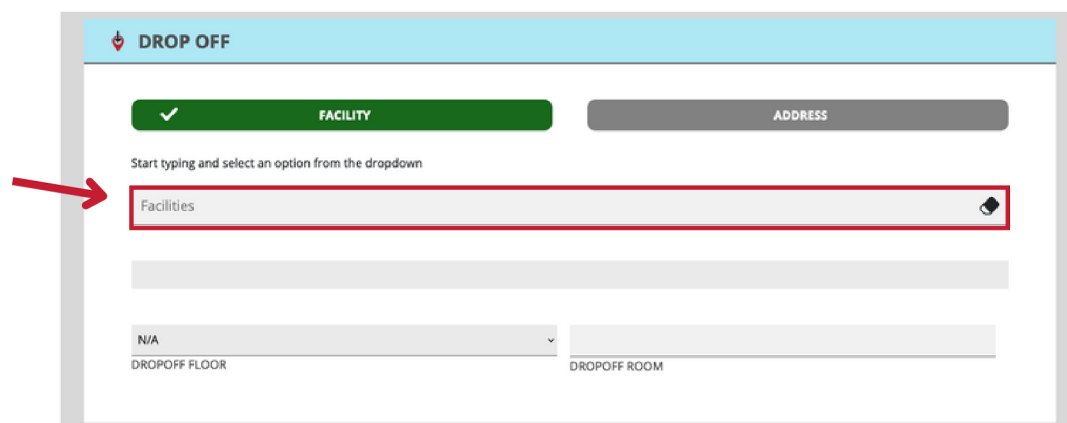
800 RIVERSIDE DR, WAUPACA, WI, 54981

PICKUP ROOM

PICKUP DATE: 05-15-2023

PICKUP TIME: NOW

SET DROP OFF LOCATION



DROP OFF

FACILITY ADDRESS

Start typing and select an option from the dropdown

Facilities

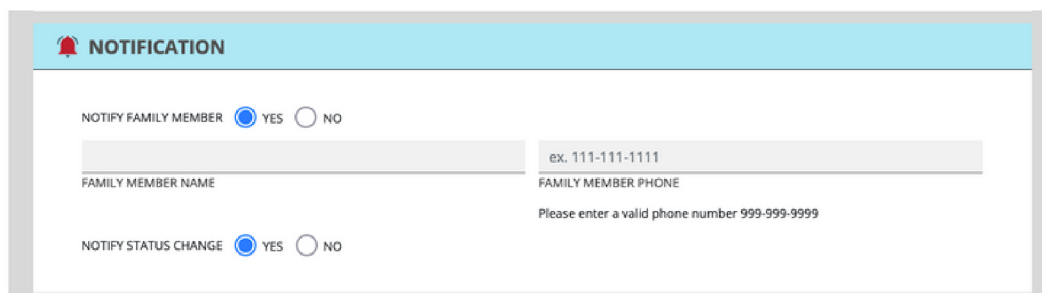
N/A

DROPOFF FLOOR

DROPOFF ROOM

SET NOTIFICATION PREFERENCES

1. To send a PHI free text to a patient's family member, select "yes" beside "Notify Family Member" then enter a name and a mobile phone number.
2. To request status change notifications be sent to the call placing user either by text or email, select "YES" beside "Notify Status Change"



NOTIFICATION

NOTIFY FAMILY MEMBER YES NO

FAMILY MEMBER NAME: _____ FAMILY MEMBER PHONE: ex. 111-111-1111

NOTIFY STATUS CHANGE YES NO

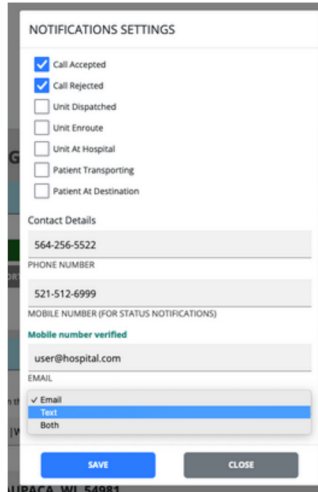
Please enter a valid phone number 999-999-9999

TO CHANGE NOTIFICATION PREFERENCES

1. Scroll to the top of the Order Form and navigate to "Settings" in the menu bar.



USER NOTIFICATION SETTINGS



NOTIFICATIONS SETTINGS

- Call Accepted
- Call Rejected
- Unit Dispatched
- Unit Enroute
- Unit At Hospital
- Patient Transporting
- Patient At Destination

Contact Details

564-256-5522
PHONE NUMBER

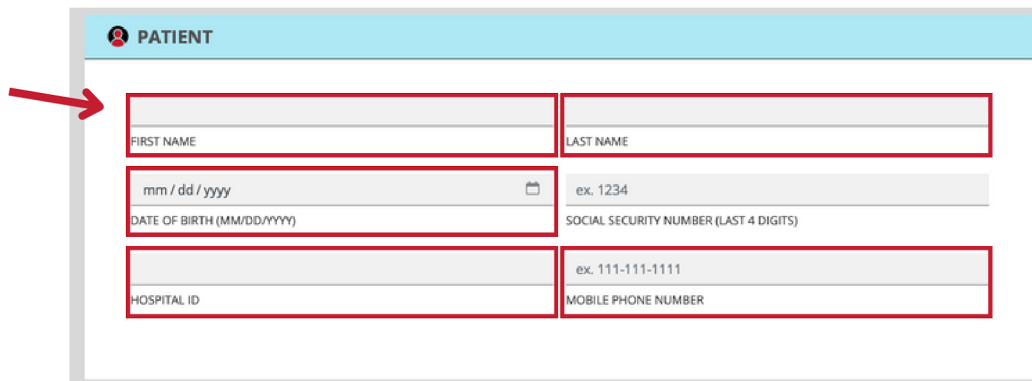
521-512-6999
MOBILE NUMBER (FOR STATUS NOTIFICATIONS)

Mobile number verified
user@hospital.com
EMAIL

Email
 Text
 Both

SAVE CLOSE

FILL IN PATIENT INFORMATION



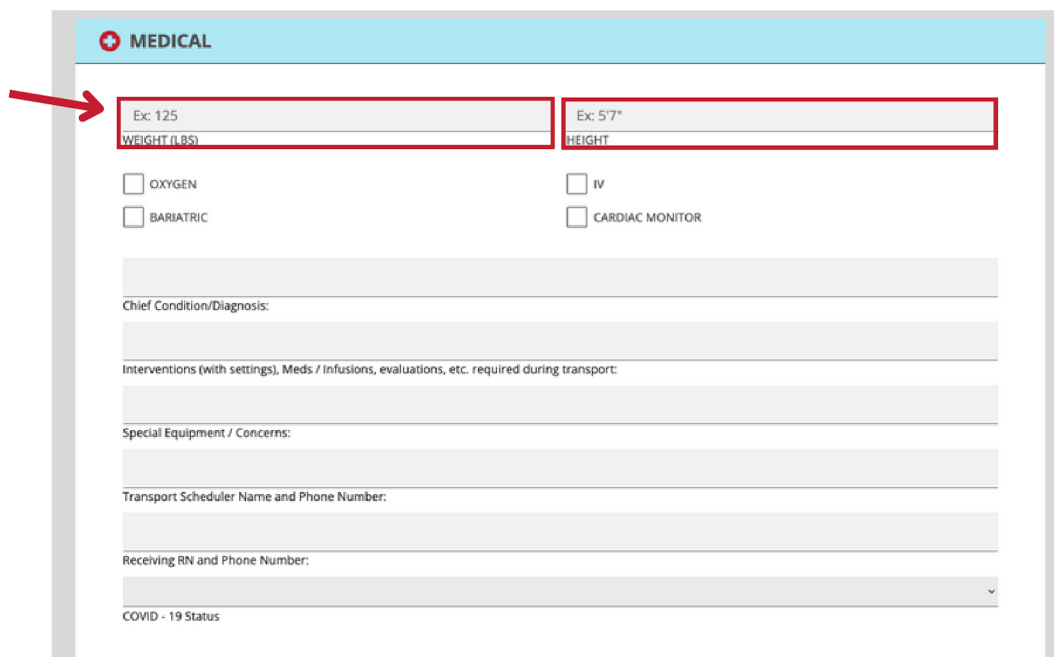
PATIENT

FIRST NAME LAST NAME

mm / dd / yyyy ex. 1234
DATE OF BIRTH (MM/DD/YYYY) SOCIAL SECURITY NUMBER (LAST 4 DIGITS)

HOSPITAL ID ex. 111-111-1111
MOBILE PHONE NUMBER

FILL IN MEDICAL INFORMATION & ANSWER RELEVANT QUESTIONS



MEDICAL

Ex: 125 Ex: 5'7"
WEIGHT (LBS) HEIGHT

OXYGEN IV
 BARIATRIC CARDIAC MONITOR

Chief Condition/Diagnosis:

Interventions (with settings), Meds / Infusions, evaluations, etc. required during transport:

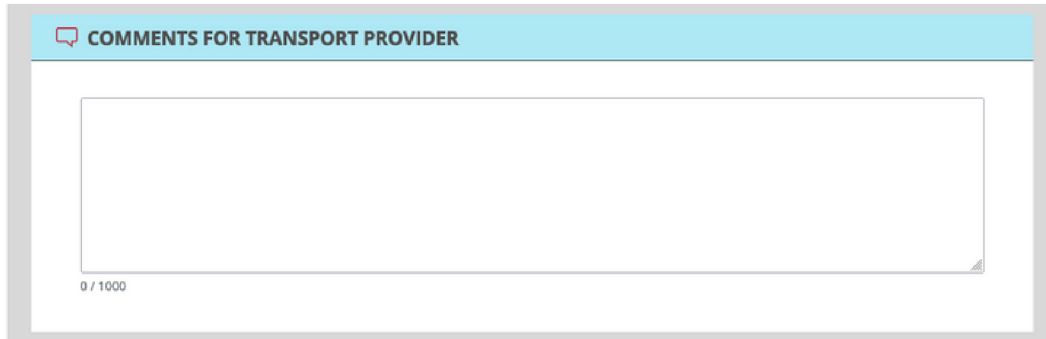
Special Equipment / Concerns:

Transport Scheduler Name and Phone Number:

Receiving RN and Phone Number:

COVID - 19 Status

ADD A COMMENT FOR TRANSPORT CREW

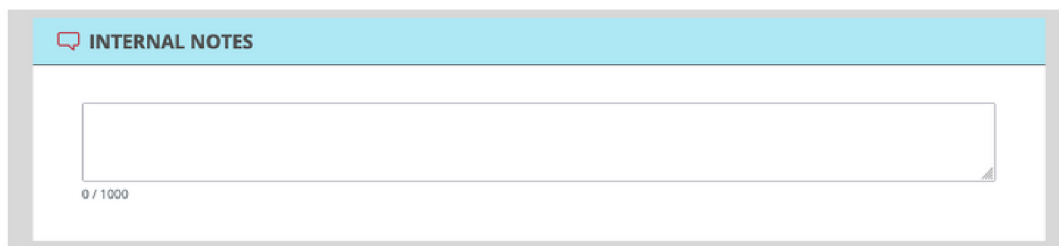


SHARE A NOTE WITH INTERDISCIPLINARY TEAM OR DISPATCHER

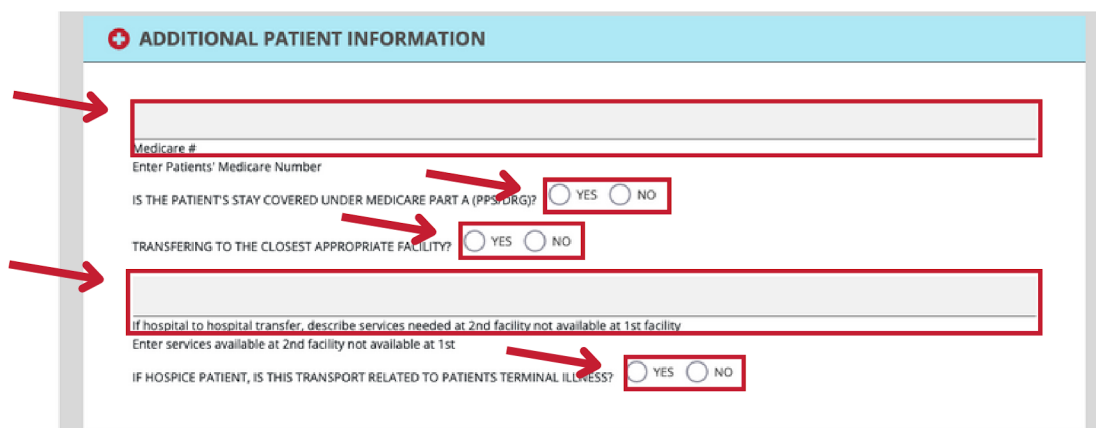
Suggested workflow using Internal Notes:

1. Social Worker starts filling out the order and enters a note to let the nurse know what is needed next and stashes the trip for later.
2. Nurse fills out relevant information and either signs the form and submits the trip OR adds a note to let users know what is still needed and stashes the trip again.
3. If the physician needs to sign the form, they would sign and submit the trip.
4. During review of the trip, if a dispatcher notes changes needed, they will be entered here.

*Note - To avoid complications of too many users editing a trip at the same time, you may find it useful to quickly note "In Progress" in this section to communicate to users that you are working on the trip request.



ADDITIONAL PATIENT INFORMATION



FILL OUT MEDICAL NECESSITY INFORMATION

Please Note: The Medical Conditions field should include very specific information regarding the **MEDICAL CONDITION** (physical and/or mental) of this patient **AT THE TIME OF AMBULANCE TRANSPORT** that requires the patient to be transported in an ambulance, and why transport by other means is contraindicated by the patients condition.

+ REPETITIVE TRANSPORTATION

REPETITIVE TRANSPORTATIONS ARE REQUIRED (DIALYSIS, RADIATION, ETC.) CHECK HERE TO VALIDATE THIS PCS FOR MAXIMUM OF 60 DAYS. **MUST BE SIGNED OFF BY A PHYSICIAN.** YES NO

+ MEDICAL NECESSITY

Ambulance Transportation is medically necessary only if the other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than an ambulance is contraindicated by the patients condition. **The following questions must be answered by the healthcare professional signing below to be valid:**

Describe the **MEDICAL CONDITION** (physical and/or mental) of this patient **AT THE TIME OF AMBULANCE TRANSPORT** that requires the patient to be transported in an ambulance, and why transport by other means is contraindicated by the patients condition:

Medical Conditions

1. UNABLE TO GET UP FROM BED WITHOUT ASSISTANCE? AND YES NO
 2. UNABLE TO AMBULATE? AND
 3. UNABLE TO SIT IN A CHAIR OR WHEELCHAIR?

CAN THIS PATIENT BE SAFELY TRANSPORTED BY CAR OR BY WHEELCHAIR VAN? (I.E., MAY BE SAFELY SIT DURING TRANSPORT, WITHOUT AN ATTENDANT OR MONITORING?) YES NO

NOTE ANY ADDITIONAL CONDITIONS THAT APPLY

+ ADDITIONAL CONDITIONS

In addition to completing the above questions, please check any of the following conditions that apply (*Note: supporting documentation for any of these selected must be maintained in the patients medical records*)

- CONTRACTURES
- NON-HEALED FRACTURES
- PATIENT IS CONFUSED
- PATIENT IS COMATOSE
- MODERATE/SEVERE PAIN ON MOVEMENT
- DANGER TO SELF/OTHERS
- IV MEDS/FLUIDS REQUIRED
- PATIENT IS COMBATIVE
- NEED, OR POSSIBLE NEED, FOR RESTRAINTS
- DVT REQUIRES ELEVATION OF A LOWER EXTREMITY
- MEDICAL ATTENDANT REQUIRED
- REQUIRES OXYGEN - UNABLE TO SELF-ADMINISTER
- SPECIAL HANDLING/ISOLATION/INFECTION CONTROL PRECAUTIONS REQUIRED
- UNABLE TO TOLERATE SEATED POSITION FOR TIME NEEDED TO TRANSPORT
- HEMODYNAMIC MONITORING REQUIRED ENROUTE
- UNABLE TO SIT IN A CHAIR OR WHEELCHAIR DUE TO DECUBITUS ULCERS OR OTHER WOUNDS
- CARDIAC MONITORING REQUIRED ENROUTE
- MORBID OBESITY REQUIRES ADDITIONAL PERSONNEL/EQUIPMENT TO SAFELY HANDLE PATIENT
- ORTHOPEDIC DEVICE (BACKBOARD, HALO, PINS, TRACTION, BRACE, WEDGE, ETC.) REQUIRING SPECIAL HANDLING DURING TRANSPORT

LIST ANY OTHER CONDITIONS NOT LISTED ABOVE

+ ANY OTHER CONDITIONS NOT LISTED ABOVE

Other conditions

FILL IN THE REQUESTING PROVIDER ATTESTATION

+ REQUESTING PROVIDER ATTESTATION

By signing below I certify that the above information is accurate based on my evaluation of this patient, and that the medical necessity provisions of 42 CFR 410.40(e)(1) are met, requiring that this patient be transported by ambulance. I understand this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services. I represent that I am the beneficiary's attending physician; or an employee of the beneficiary's attending physician, or the hospital or facility where the beneficiary is being treated and from which the beneficiary is being transported; that I have personal knowledge of the beneficiary's condition at the time of transport; and that I meet all Medicare regulations and applicable State licensure laws for the credential indicated.

IF THIS BOX IS CHECKED, I ALSO CERTIFY THAT THE PATIENT IS PHYSICALLY OR MENTALLY INCAPABLE OF SIGNING THE AMBULANCE SERVICES CLAIM FORM AND THAT THE INSTITUTION WITH WHICH I AM AFFILIATED HAS FURNISHED CARE, SERVICES OR ASSISTANCE TO THE PATIENT. MY SIGNATURE BELOW IS MADE ON BEHALF OF THE PATIENT PURSUANT TO 42 CFR 94.24.36(B)(4). IN ACCORDANCE WITH 42 CFR 94.24.37, THE SPECIFIC REASON(S) THAT THE PATIENT IS PHYSICALLY OR MENTALLY INCAPABLE OF SIGNING THE CLAIM FORM IS AS FOLLOWS:

Reasons

PROVIDER TYPE **SELECT A PROVIDER TYPE ...**

- MD
- DO
- Physician Assistant
- Clinical Nurse Specialist
- LPN
- Case Manager
- Nurse Practitioner
- RN
- Social Worker
- Discharge Planner

05-16-2023
Date

Kathryn Rei
Name

SIGNATURE [CLEAR SIGNATURE](#)

By pressing SUBMIT I attest that I am the above named provider, I am digitally signing this form and that my digital signature is equivalent to my written signature in this instance. I understand that all use of this system is logged.

SIGN THE FORM LEGIBLY WITH YOUR MOUSE

PROVIDER TYPE RN

05-16-2023
Date

Jane Doe
Name

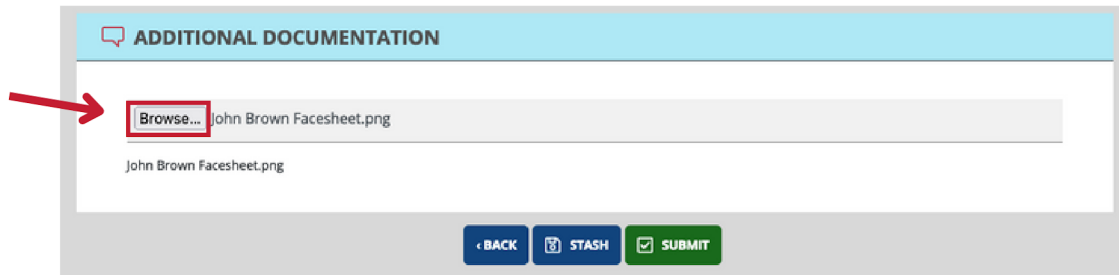


SIGNATURE [CLEAR SIGNATURE](#)

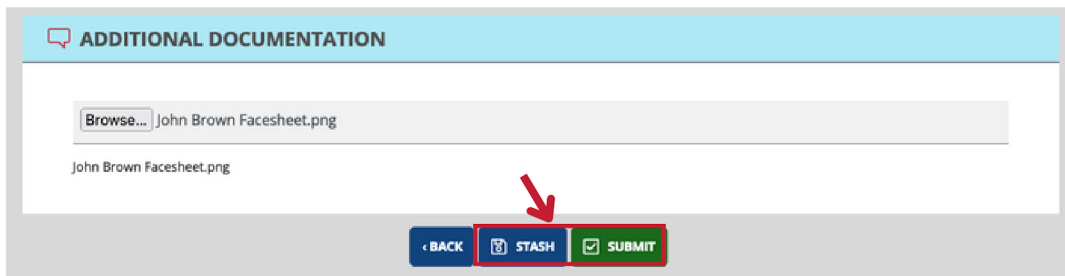
By pressing SUBMIT I attest that I am the above named provider, I am digitally signing this form and that my digital signature is equivalent to my written signature in this instance. I understand that all use of this system is logged.

ATTACH THE PATIENT'S FACESHEET

To facilitate Gold Cross handling the pre-authorization call to Veyo, please be sure to attach the patient's facesheet prior to submitting the trip request.

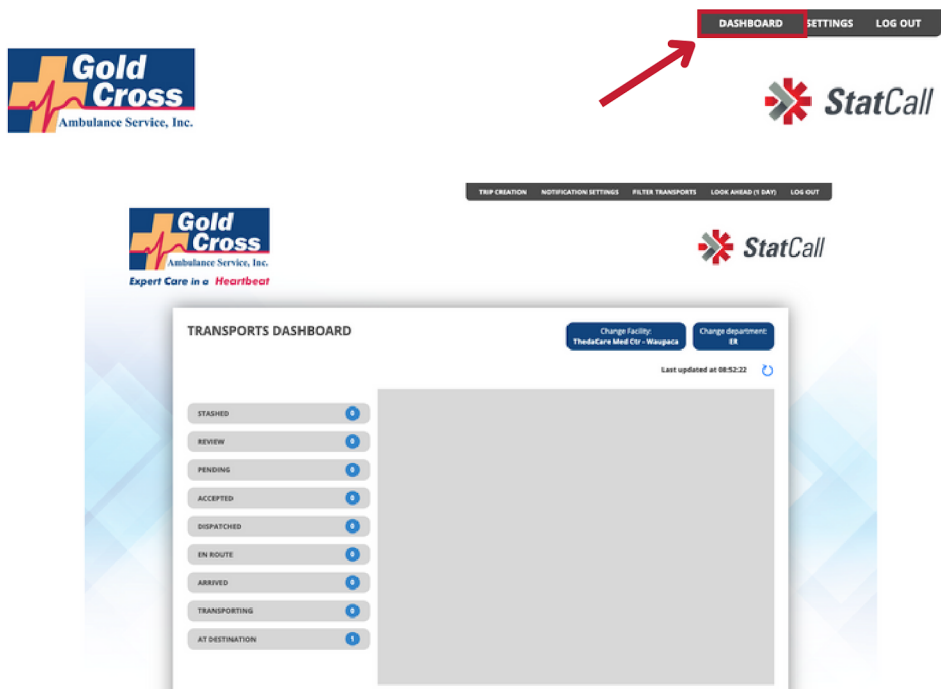


STASH THE TRIP FOR LATER OR SUBMIT TRIP FOR REVIEW BY A DISPATCHER



ACCESS STASHED TRIPS OR MONITOR TRIP STATUS

Navigate to Dashboard in the top menu bar.



SUPPORT

Submit a support ticket to jiangnese@goldcross.org

