



# MEDICS Ambulance Service

378 S.W. 12<sup>TH</sup> AVENUE  
DEERFEILD BEACH, FLORIDA 33442

## REPETITIVE PATIENT QUESTIONNAIRE

DATE: \_\_\_\_\_

### **PERSONAL INFORMATION:**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Physician/Primary: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax #: \_\_\_\_\_

Physician/Specialist: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax #: \_\_\_\_\_

### **INSURANCE INFORMATION:**

SSN#: \_\_\_\_\_ Medicare #: \_\_\_\_\_

Medicaid #: \_\_\_\_\_ Other #: \_\_\_\_\_

Other insurance information \_\_\_\_\_

\_\_\_\_\_

1. How often does the patient go to (circle one) dialysis, hyperbaric, or radiation therapy?

\_\_\_\_\_

2. How long has the patient been going for this type of therapy? \_\_\_\_\_

\_\_\_\_\_

3. How has the patient been going to \_\_\_\_\_?  
(Name of facility)

\_\_\_\_\_

4. Does the patient's condition now contraindicate transportation by means other than an ambulance stretcher? Yes No

Why? \_\_\_\_\_

5. Does the patient feel that he/she could not tolerate traveling by car or wheelchair van without endangering his/her health? Yes No

Why? \_\_\_\_\_

6. What personal care activities can the patient perform unassisted?

Brush Hair

Toilet Activities

Dress Self

Shave

Brush Teeth

Bathe

Feed Self

7. Is the patient able to stand unassisted? Yes No

8. Is the patient able to stand when assisted? Yes No

Explain: \_\_\_\_\_

\_\_\_\_\_

9. How much assistance is required? Minimum Moderate Maximum

10. Is the patient able to get from the bed to the wheelchair unassisted? Yes No N/A

11. Is the patient able to get from the bed to the wheelchair if assisted? Yes No N/A

Explain: \_\_\_\_\_

12. Is the patient able to walk? Yes No

If no, why? \_\_\_\_\_  
\_\_\_\_\_

13. How long has the patient been unable to walk? \_\_\_\_\_

14. Does the patient prepare his/her own meals? \_\_\_\_\_

15. If not, how does the patient get his/her meals? \_\_\_\_\_  
\_\_\_\_\_

16. Is the patient able to get from a wheelchair to a car without assistance? Yes No

17. Is the patient able to get from a wheelchair to a car with assistance? Yes No

Explain: \_\_\_\_\_  
\_\_\_\_\_

18. Does the patient ever go anywhere by car or other means of transportation? Yes No

Explain: \_\_\_\_\_  
\_\_\_\_\_

19. Is the patient able to ride in a car? Yes No

20. Does the patient have any items of durable medical equipment (i.e, wheelchair, walker, commode chair, cane crutches, oxygen equipment, etc)? Yes No

If the above is yes, do they currently use it? Yes No

21. Has the patient ever suffered any complications after completing a \_\_\_\_\_ treatment? Yes No

Explain: \_\_\_\_\_

22. If a disaster or an emergency were to occur in your home and you were there alone, would the patient be able to get into a wheelchair (or otherwise remove themselves from the house) and go safely outside? Yes No

23. Is the patient bed confined? Yes No

Explain: \_\_\_\_\_

24. Is the patient non-ambulatory? Yes No

Explain: \_\_\_\_\_

25. List any relevant history: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

26. List the patient's diagnosis and current conditions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

27. Is the patient able to be transported by wheelchair van or car?  Yes  No

28. List the specific reasons why the patient can only be transported by ambulance: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

29. Does the patient have any Certificate of Medical Necessity:  
-from the physician?  Yes  No  
-from the nursing home?  Yes  No  
-from the dialysis facility?  Yes  No

If yes was answered to any of the above, please obtain a copy of CMN.

30. Is the dialysis facility:  
-hospital based?  Yes  No  
-at or adjacent to a hospital?  Yes  No  
-free standing  Yes  No

31. Where does the patient reside?  
-at home, care for by family?  Yes  No  
-skilled nursing home?  Yes  No  
- extended care facility  Yes  No  
-other, explain.

\_\_\_\_\_  
\_\_\_\_\_

**COMMENTS:**

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Responsible person/ contact: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Contact Telephone Numbers(s): \_\_\_\_\_

Printed Name of person preparing report: \_\_\_\_\_

Signed Name of person preparing report: \_\_\_\_\_

State License Number: \_\_\_\_\_ Certification: \_\_\_\_\_

Video Tape of Patient Assessment made: Yes No If yes, date: \_\_\_\_\_

Approved for transportation by Medics Ambulance Service: Yes No

Approved by: \_\_\_\_\_

Title: \_\_\_\_\_