

EMS Patient Refusal Checklist

EMS Service: _____ Date: _____ Time: _____

Patient Name: _____ Age: _____ Phone #: _____

Incident Location: _____ Incident # _____

Situation of Injury/Illness: _____

Check marks in shaded areas require consult with Medical Command before patient release

Patient Assessment:

Suspected serious injury or illness based upon patient

History, mechanism of injury, or physical examination: Yes No

18 years of age or older: Yes No Any evidence of: Suicide attempt? Yes No

Head Injury? Yes No

Patient Oriented to: Person Yes No

Intoxication? Yes No

Place Yes No

Chest Pain? Yes No

Time Yes No

Dyspnea? Yes No

Event Yes No

Syncope? Yes No

Vital Signs:	Consult Medical Command if:	If altered mental status or diabetic -(ALS only)- Chemstrip/Glucometer: _____mg/dl <input checked="" type="checkbox"/> < 60mg/dl
Pulse _____	<50bpm or >100 bpm	If chest pain, S.O.B. or altered mental status -- SpO2 (if available): _____% <input checked="" type="checkbox"/> < 95%
Sys BP _____	<100 mm Hg or > 200 mm Hg	
Dia BP _____	<50 mm Hg or > 100 mm Hg	
Resp _____	< 12rpm or > 24rpm	

Risks explained to patient: _____

Patient understands clinical situation Yes No

Patient verbalizes understanding of risks Yes No

Patient's plan to seek further medical evaluation: _____

Medical Command:

Physician contacted: _____ Facility: _____ Time: _____

Command spoke to patient: Yes No Command not contacted Why? _____

Medical Command orders: _____

Patient Outcome:

- Patient refuses transport to a hospital against EMS advice
- Patient accepts transportation to hospital by EMS but refuses any or all treatment offered (specify treatments refused: _____)
- Patient does not desire transport to hospital by ambulance, EMS believe alternative treatment/transportation plan is reasonable

This form is being provided to me because I have refused assessment, treatment and/or transport by EMS personnel for myself or on behalf of this patient. I understand that EMS personnel are not physicians and are not qualified or authorized to make a diagnosis and that their care is not a substitute for that of a physician. I recognize that there may be a serious injury or illness which could get worse without medical attention even though I (or the patient) may feel fine at the present time. I understand that I may change my mind and call 911 if treatment or assistance is needed later. I also understand that treatment is available at an emergency department 24 hours a day. I acknowledge that this advice has been explained to me by the ambulance crew and that I have read this form completely and understand its terms.

Signature (Patient or Other) Date EMS Provider Signature

If other than patient, print name and relationship to patient Witness Signature