

# EMS PATIENT REFUSAL CHECK LIST

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Location of Call: \_\_\_\_\_ IN #: \_\_\_\_\_

**A. Assessment of Patient** (Complete each item, circle appropriate response)

- |    |   |        |
|----|---|--------|
| 1. | Oriented to: <u>Person?</u> Yes No <u>Place?</u> Yes No <u>Time?</u> Yes No <u>Event?</u> Yes No                            |        |
| 2. | Normal level of consciousness?  | Yes No |
| 3. | No evidence of head injury or illness that may interfere with mental function?  | Yes No |
| 4. | No evidence of alcohol or drug ingestion by exam or history?  | Yes No |
| 5. | Vital Signs obtained and normal   | Yes No |
| 6. | Patient understands implications of decision and is capable of repeating it back to the EMS Personnel in his/her own words. | Yes No |

**B. Medical Control**

Contacted by: \_\_\_\_\_ Radio \_\_\_\_\_ at \_\_\_\_\_ hours  
\_\_\_\_ Unable to contact (explain in comments section)  
\_\_\_\_ Contact not indicated. All questions in section A are answered yes.  
Name of Hospital and Doctor: \_\_\_\_\_

Orders:

- \_\_\_\_ Indicated treatment and/or transport may be refused by patient.  
\_\_\_\_ Use reasonable force and/or restraints to provide indicated treatment. Patient declared incompetent.  
\_\_\_\_ Use reasonable force and/or restraint to transport. Patient declared incompetent.  
\_\_\_\_ Elicit law enforcement assistance

Other orders or information: \_\_\_\_\_

**C. Patient Advised** (Complete each item, circle appropriate response)

- Yes No Seek medical care on own  
Yes No Re-contact EMS if condition worsens  
Yes No What medical treatment/evaluation needed.  
Yes No Ambulance transport needed.  
Yes No Further harm could result without medical treatment/evaluation.  
Yes No In light of patient's illness/injury, ambulance transport is indicated to minimize further harm/hazards.

**D. Disposition**

- \_\_\_\_ Refused all EMS services.  
\_\_\_\_ Refused transport, accepted field treatment.  
\_\_\_\_ Refused field treatment, accepted transport.  
\_\_\_\_ Released in care or custody of self.  
\_\_\_\_ Release in custody of law enforcement agency.  
Agency: \_\_\_\_\_ Officer: \_\_\_\_\_  
\_\_\_\_ Released in care or custody of: \_\_\_\_\_ Relative \_\_\_\_\_ Friend  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

- Patient provided with EMS Refusal Information Sheet.  
 Patient would not accept EMS Refusal Information Sheet.

**E. Comments:** (Use back of page, if additional space is needed) \_\_\_\_\_  
\_\_\_\_\_

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Signature of Provider \_\_\_\_\_ Date \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_