

ALLIED EMS Patient Refusal Check List

Name: _____

Age: _____ Date: _____

Location of Call _____ Incident# _____

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

- 1. Oriented to: Person? Yes No Place? Yes No Time? Yes No Situation Yes No
- 2. Altered level of consciousness? Yes No
- 3. Head Injury? Yes No
- 4. Alcohol or drug ingestion by exam of history? Yes No

II. Medical Control

_____ Contacted by: _____ Phone _____ Radio at _____ hours.

_____ Unable to contact (explain in comments)

Orders:

_____ Indicated treatment and/or transport may be refused by patient.

_____ Use reasonable force and/or restraints to provide indicated treatment.

_____ Use reasonable force and/or restraint to transport.

Other:

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

Yes No Medical treatment /evaluation needed.

Yes No Ambulance transport needed.

Yes No Further harm could result without medical treatment/evaluation.

Yes No Transport by means other than ambulance could be hazardous in light of patient's present illness/injury.

Yes No Patient provided with refusal advise sheet.

Yes No Patient would not accept refusal advise sheet.

IV. Disposition

_____ Refused all EMS services.

_____ Refused transport, accepted field treatment.

_____ Refused field treatment, accepted transport.

_____ Released in care of custody of self.

_____ Released in custody of law enforcement agency:

Agency: _____ Officer: _____

_____ Released in care of custody: of relative of friend

Name: _____ Relationship: _____

V. Comments: (use back of page, if additional space is needed)

Signature of Provider

Date _____

Signature of Provider

