EMS Patient Non-Treatment and/or Non-Transport Checklist

EMS Agency:_____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
Without ability to speak with guardian
Patient Oriented to: Person_____Yes ___ No
Place ___Yes ___ No
Time ___Yes ___ No
Event ___Yes ___ No

Any evidence of: Suicide attempt/ideation? ___ Yes ___No
Head Injury? ___ Yes ___No
Intoxication? ___ Yes ___No
Chest Pain? ___ Yes ___No
Dyspnea? ___ Yes ___No
Syncope? ___ Yes ___No
If head trauma & taking aspirin/anticoagulant? ___ Yes ___No

12-lead done? ___ Yes ___No

Vital Signs:	***Consult Medical Command if:***
Pulse _____	<50bpm or >100 bpm
Sys BP__	<100 mm Hg or > 200 mm Hg
Dia BP__	<50 mm Hg or > 100 mm Hg
Resp _____	< 12rpm or > 24rpm

If altered mental status or diabetic (optional for BLS)
Chemstrip/Glucometer:_____mg/dl < 60 mg/dl

If chest pain, S.O.B. or altered mental status --
SpO2 (if available):_____% < 95%

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 treatment/ 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 an EMS provider for myself or on behalf of this patient. I understand that EMS providers 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 EMS 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