



EMS Patient Refusal Check List

Name: _____ Age: _____ Date: _____

Location of Call: _____ Report #: _____

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 _____ Date _____