

EMS PATIENT REFUSAL CHECKLIST

Name: _____ Age: _____ Date: _____
Location of Call: _____ Report #: _____

Assessment of Patient (complete each item, circle appropriate response)

- Oriented to: Person? Yes No Place? Yes No Time? Yes No Situation? Yes No
- Altered level of confusion? Yes No
- Head injury? Yes No
- Alcohol or drug ingestion by exam of history? Yes No

Medical Control (complete each item, check appropriate response)

_____ Contacted by: _____ Phone _____ Radio at _____ hours
_____ Unable to contact (explain in comments)

Orders:

- _____ Indicated treatment and/or transport may be refused by the patient.
_____ Use reasonable force and/or restraints to provide indicated treatment.
_____ Use reasonable force and/or restraints to transport.

Comments: _____

Patient Advised (complete each item, circle appropriate response)

- Yes No Medical treatment/evaluation needed.
Yes No Ambulance transport needed.
Yes No Further harm or death 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 advice sheet.
Yes No Patient would not accept refusal advice sheet.

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 or friend.

Name: _____ Relationship: _____

Comments (use back of page for additional space) _____

Signature of Provider: _____ Date: _____

Signature of Provider: _____ Date: _____