



Short Form Patient Information Sheet 2012

Jurisdiction: _____ Date: _____

Incident # _____ Time Arrived at Hospital: _____

Unit #: _____

Age: _____ DOB: _____ Wt: _____ Kg Gender: M F

Priority: 1 2 3 4 Trauma Category: A B C D

Patient's Name: _____

Patient's Address: _____

City: _____ State: _____

Point of Contact: _____ Phone Number: _____

Chief Complaint: _____

Time of Onset: _____ Past Medical History: (DNR/MOLST A1 A2 B)

Cardiac CHF Hypertension Seizure Diabetes COPD Asthma

Other: _____

Current Meds: _____

Allergies: Latex Penicillin/Ceph Sulfa Other: _____

Assessments

Vitals Time: _____ B/P: _____ / _____ Pulse: _____ Respirations: _____ SAO2: _____ % Capnography: _____ Carbon Monoxide: _____ Repeat Vitals Time: _____ B/P: _____ / _____ Pulse: _____ Respirations: _____ SAO2: _____ % Capnography: _____ Carbon Monoxide: _____	Respiration Left Right <input type="checkbox"/> Clear <input type="checkbox"/> <input type="checkbox"/> Rales <input type="checkbox"/> <input type="checkbox"/> Labored <input type="checkbox"/> <input type="checkbox"/> Stridor <input type="checkbox"/> <input type="checkbox"/> Rhonchi <input type="checkbox"/> <input type="checkbox"/> Wheezes <input type="checkbox"/> <input type="checkbox"/> Decreased <input type="checkbox"/> <input type="checkbox"/> Agonal <input type="checkbox"/> <input type="checkbox"/> Absent <input type="checkbox"/>	Skin <input type="checkbox"/> Warm <input type="checkbox"/> Hot <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Clammy <input type="checkbox"/> Diaphoretic <input type="checkbox"/> Cyanotic	GCS Eyes (4): _____ Verbal (5): _____ Motor (6): _____ TOTAL: _____
	Pulse <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> JVD <input type="checkbox"/> Peripheral Edema Cap Refill: _____ seconds	Pupils <input type="checkbox"/> PERRL <input type="checkbox"/> Unequal <input type="checkbox"/> Fixed/Dilated	Neuro <input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> P <input type="checkbox"/> U

Assessment

Procedures

Cardiac Rhythm: _____ 12 Lead Transmit Yes <input type="checkbox"/> No <input type="checkbox"/> Perform 12 Lead Yes <input type="checkbox"/> No <input type="checkbox"/> Glucometer: _____ <input type="checkbox"/> IV1 <input type="checkbox"/> IV2 <input type="checkbox"/> IO <input type="checkbox"/> EJ Amount Infused: _____	Cincinnati Stroke Scale <i>Normal/Abnormal</i> Facial Droop Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Arm Drift Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Speech Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Last Known Well Time/Date: _____
CPR Performed Yes <input type="checkbox"/> No <input type="checkbox"/> ROSC Yes <input type="checkbox"/> No <input type="checkbox"/> Induced Hypothermia Yes <input type="checkbox"/> No <input type="checkbox"/>	Oxygen <input type="checkbox"/> NRB Mask <input type="checkbox"/> King Airway <input type="checkbox"/> Nasal Cannula <input type="checkbox"/> CPAP <input type="checkbox"/> NPA/OPA <input type="checkbox"/> NDT <input type="checkbox"/> BVM <input type="checkbox"/> Ventilator <input type="checkbox"/> ET <input type="checkbox"/> NT <input type="checkbox"/> NGT <input type="checkbox"/> Easy Tube

Treatment:

Jurisdictional Additions:

Patient Signature

Receiving Facility Representative Signature and Name

Print Provider Name: _____

Section One:

When encountering a patient that is attempting to refuse EMS treatment or transport, assess their condition, and record whether the patient screening reveals any lack of medical decision-making capability (1-3,4a or b) or high risk criteria (5-8):

- | | | | | |
|--|---|------------------------------|------------------------------|-----------------------------|
| Medical
Capacity | 1. Disoriented to: | Person? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | | Place? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | | Time? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | | Situation? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | 2. Altered level of consciousness? | | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | 3. Alcohol or drug ingestion by history or exam with: | | | |
| | a. Slurred speech? | | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | b. Unsteady gait? | | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | 4. Patient does not understand the nature of illness and potential for bad outcome? | | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | | | If yes, transport | |
| At Risk
Criteria | 5. Abnormal vital signs | | | |
| | For Adults | | | |
| | Pulse greater than 120 or less than 60? | | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | Systolic BP less than 90? | | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | Respirations greater than 30 or less than 10? | | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | For minor/pediatric patients | | | |
| | Age inappropriate HR or | | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | Age inappropriate RR or | | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | Age inappropriate BP | | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | 6. Serious chief complaint (chest pain, SOB, syncope) | | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 7. Head Injury with history of loss of consciousness? | | <input type="checkbox"/> yes | <input type="checkbox"/> no | |
| 8. Significant MOI or high suspicion of injury | | <input type="checkbox"/> yes | <input type="checkbox"/> no | |
| 9. For minor/pediatric patients: ALTE, significant past medical history, or suspected intentional injury | | <input type="checkbox"/> yes | <input type="checkbox"/> no | |
| 10. Provider impression is that the patient requires hospital evaluation | | If yes, consult | | |
| | | <input type="checkbox"/> yes | <input type="checkbox"/> no | |

Section Two:

For providers: Following your evaluation, document information and care below:

- Did you perform an assessment (including exam) on this patient? yes no
If yes to #1, skip to #3
- If unable to examine, did you attempt vital signs? yes no
- Did you attempt to convince the patient or guardian to accept transport? yes no
- Did you contact medical direction for patient still refusing service? yes no

Patient Refusal of EMS

I, _____, have been offered the following by _____ (EMS Operational Program) but refuse (check all that apply):

- Examination Treatment Transport

Patient Name: _____ Phone: _____

Patient Address: _____

Signature: _____ Witness: _____

- Patient Parent Guardian Authorized Decision Maker (ADM)

If you experience new symptoms or return of symptoms after this encounter, we recommend that you seek medical attention promptly.

Section Three: (CHECK ALL THAT APPLY)

Initial Disposition:

- Patient refused exam Patient refused treatment Patient refused transport
 Patient accepted exam Patient accepted treatment Patient accepted transport
 ADM refused exam ADM refused treatment ADM refused transport

Interventions:

- Attempt to convince patient Attempt to convince family member/ADM
 Contact Medical Direction (Facility: _____)
 Contact Law Enforcement None of the above available

Final Disposition:

- Patient refused exam Patient refused treatment Patient refused transport
 Patient accepted exam Patient accepted treatment Patient accepted transport
 ADM refused exam ADM refused treatment ADM refused transport

Section Four: (MUST COMPLETE)

Provide in the patient's own words why he/she refused the above care/service:

Jurisdiction _____ Incident: _____ Date: _____
Unit #: _____ Provider Name/EID: _____ Time: _____