DETOX MEDICAL CLEARANCE FORM

Patient Name: **Date:**
DOB: **Tag #:**

ASSESSMENT

Please check the appropriate answer to the following assessment questions.

*Must answer **YES** to be cleared*	**YES**	NO	Comments
Ambulatory:	☐	☐	
>18 years of age:	☐	☐	
Responds appropriately to questions:	☐	☐	

*Must answer **NO** to be cleared.*	YES	**NO**	Comments
Seizure in last 24 hours:	☐	☐	
Incontinent:	☐	☐	Urine Feces
Combative:	☐	☐	
Delirium Tremens:	☐	☐	
Suicidal/Homicidal:	☐	☐	
Open Sores:	☐	☐	
Catheter/Colostomy:	☐	☐	
Uncontrollable Nausea/Vomiting/Diarrhea:	☐	☐	
Head Injury with disorientation:	☐	☐	
Acute exacerbation of chronic medical problem:	☐	☐	
Taking blood thinners such as coumadin:	☐	☐	
Needing or taking an anti-emetic:	☐	☐	
Ingested Ketamine, Ecstasy, GHB, Rohypnol:	☐	☐	

Breathalyzer:		≤ 0.40
Pulse Rate:		< 120 bpm
Blood Pressure:		<160/110 or >90/50 mm/Hg
Respiratory Rate:		12-24 resp/min
Oximetry:		> 90%
Glucose:		60-350mg/dl

On Line Medical Control
Physician Name:
Facility:
Comments:

PLAN OF ACTION

The above named patient has been assessed, on line medical control has been contacted and the patient has been found:

☐ Medically cleared to remain at detox.

☐ **Not** medically cleared to remain at detox.

If the patient's status should change, call 911 or the AMR dispatch center number.

Paramedic Signature:	Employee Number:
Detox Staff Signature:	Printed Name: