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? ❑ yes ❑ no
   Place? ❑ yes ❑ no
   Time? ❑ yes ❑ no
   Situation? ❑ yes ❑ no
2. Altered level of consciousness? ❑ yes ❑ no
3. Alcohol or drug ingestion by history or exam with:
   a. Slurred speech? ❑ yes ❑ no
   b. Unsteady gait? ❑ yes ❑ no
4. Patient does not understand the nature of illness and potential for bad outcome? ❑ yes ❑ no

If yes, transport

At Risk Criteria

5. Abnormal vital signs
   For Adults
   Pulse greater than 120 or less than 60? ❑ yes ❑ no
   Systolic BP less than 90? ❑ yes ❑ no
   Respirations greater than 30 or less than 10? ❑ yes ❑ no
   For minor/pediatric patients
   Age inappropriate HR or ❑ yes ❑ no
   Age inappropriate RR or ❑ yes ❑ no
   Age inappropriate BP ❑ yes ❑ no
6. Serious chief complaint (chest pain, SOB, syncope) ❑ yes ❑ no
7. Head Injury with history of loss of consciousness? ❑ yes ❑ no
8. Significant MOI or high suspicion of injury ❑ yes ❑ no
9. For minor/pediatric patients: ALTE, significant past medical history, or suspected intentional injury ❑ yes ❑ no
10. Provider impression is that the patient requires hospital evaluation

If yes, consult

❑ yes ❑ no

Section Two:

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

1. Did you perform an assessment (including exam) on this patient? ❑ yes ❑ no
   If yes to #1, skip to #3
2. If unable to examine, did you attempt vital signs? ❑ yes ❑ no
3. Did you attempt to convince the patient or guardian to accept transport? ❑ yes ❑ no
4. 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: _____