PATIENT ASSESSMENT

Patient Name: ___________________________ Date: ___________________________

(A) LEGAL CAPACITY

NOTE: If answer to at least one of the questions in this section is “YES,” the patient may sign this form in most states. If “NO” to all, signature of legally authorized decisionmaker required. Check your state law for other exceptions.

Patient over 18? Yes No If minor, is patient married? Yes No If minor, is patient pregnant? Yes No

Comments/Quotes/Observations: _______________________________________

(B) MENTAL CAPACITY

NOTE: If “YES” to any question in (B), Patient may lack capacity to refuse care, though this is a fact-specific determination and consultation with medical command is encouraged. Do not release Patient or allow to sign Form unless explanation noted or, if Patient is less than 18 years of age, the Form is signed by Parent or legal guardian.

Disoriented to: Person? Yes No Possible ETOH / drug use? Yes No Odor of ETOH? Yes No
Place? Yes No Admitted by Patient? Yes No Unsteady gait? Yes No
Time? Yes No Slurred speech? Yes No

Comments/Quotes/Observations: _______________________________________

(C) MEDICAL CAPACITY

NOTE: If “YES” to any question in (C), Patient may lack capacity to refuse care, though this is a fact-specific determination and consultation with medical command is encouraged. Do not release Patient or allow to sign Form unless explanation noted or, if Patient is less than 18 years of age, the Form is signed by Parent or legal guardian.

Head injury? Yes No ALOC? Yes No Abnormal glucose? Yes No Reading: __________
Abnormal pupils? Yes No Severe SOB? Yes No Abnormal SA02? Yes No Reading: __________

Comments/Quotes/Observations: _______________________________________

(D) MEDICAL COMMAND

Physician name: ___________________________ Contacted by: phone ______ radio ______ on scene ______
Orders: Release Patient ______ Use Reasonable Force/Restraint to Treat ______ Transport ______

Comments/Quotes/Observations: _______________________________________

(E) DESTINATION/DIVERT

Diverted by: ___________________________ Diverted to: ___________________________
Reason: ___________________________

Destination instructions voiced by patient: ______________________________________

(F) PROVIDER SIGNATURE

Crew Member Signature: ___________________________ ID. No. __________________
PATIENT NAME: ___________________________  DATE: _______________________

This form is being provided to me because I have: (check all that apply)

☐ REFUSED ASSESSMENT  ☐ REFUSED TREATMENT  ☐ REFUSED TRANSPORT

☐ INSISTED ON BEING TRANSPORTED TO A HOSPITAL OTHER THAN THAT WHICH THE EMS PERSONNEL RECOMMEND

I understand that the EMS personnel are not physicians and are not qualified or authorized to make a diagnosis and that their care is not a substitute for that of a physician. I recognize that I may have a serious injury or illness which could get worse without medical attention even though I (or the patient on whose behalf I legally sign this document) may feel fine at the present time.

I understand that I may change my mind and call 9-1-1 if treatment or assistance is needed later. I also understand that treatment is available at an emergency department 24 hours a day or from my physician. If I have insisted on being transported to a destination other than that recommended by the EMS personnel, I understand and have been informed that there may be a significant delay in receiving care at the emergency room, that the emergency room may lack the staff, equipment, beds or resources to care for me promptly, and/or that I might not be able to be admitted to that hospital.

I acknowledge that this advice has been explained to me by the ambulance crew and that I have read this form completely and understand its provisions. I agree, on my own behalf (and on behalf of the patient for whom I legally sign this document), to release, indemnify and hold harmless the ambulance service and its officers, members, employees or other agents, and the medical command physician and medical command facility, from any and all claims, actions, causes of action, damages, or legal liabilities of any kind arising out of my decision, or from any act or omission of the ambulance service or its crew, or the medical command physician or medical command facility.

I also acknowledge receipt of the ambulance service’s Notice of Privacy Practices.

OTHER SPECIFIC INSTRUCTIONS TO PATIENT: ____________________________________________

Signature of:  Patient ☐  Parent ☐  Legal Guardian ☐  Date

Witness Signature

IF PATIENT REFUSES TO SIGN: I attest that the patient has refused care and/or transportation by the emergency medical services providers. The patient was informed of the risks of this refusal and refused to sign this form when asked by the EMS providers.

Witness Signature  Print Name

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