PEORIA AREA EMS REFUSAL FORM AND INSTRUCTIONS

AGENCY	DATE/TIME OF CALL	PATIENT'S NAME

SECTION A: MEDICAL DECISION MAKING CAPACITY *(Must be completed by medical provider)*

1. New onset of altered mental status?	☐ YES	☐ NO
2. Known or suspected head trauma?	☐ YES	☐ NO
3. Active suicidal ideations or evidence of recent self-inflicted harm present?	☐ YES	☐ NO
4. Is there any loss of consciousness associated with this incident?	☐ YES	☐ NO
5. Does the patient present as a significant life threat to self or others?	☐ YES	☐ NO
6. Did the patient score greater than 8 on the capacity exam? *(see checklist on back of this page)*	☐ YES	☐ NO
7. Is the patient unable to communicate choice? Is there a language barrier?	☐ YES	☐ NO
8. Is the patient under the age of 18?	☐ YES	☐ NO
9. Is the patient unable to engage in reasoning about treatment options?	☐ YES	☐ NO
10. Is the patient under the influence of alcohol or medication to the point of altering judgment and/or decision making capacity? *(see list on back of this page)*	☐ YES	☐ NO

If **YES** is checked to any of the questions, and the patient is refusing EMS care and/or transport, they may not have adequate decision making capabilities. Medical control should be contacted.

Telemetry Run #

SECTION B: ASSESSMENT/TREATMENT REFUSED *(Check all the apply)*

☐ Patient deemed to have decision making capacity, refuses all EMS care and ambulance transportation.
☐ Patient deemed to have the capacity, accepts the following pre-hospital care; yet refuses transport. (List care below)

_____

_____

☐ Patient deemed competent, accepts ambulance transportation, but refuses the following pre-hospital care
(Check all that apply)

☐ Oxygen ☐ Physical Exam ☐ IV access ☐ Spinal Precautions ☐ EKG application
☐ Vital Sign assessment ☐ Medication_____ ☐ Other_____

SECTION C: PATIENT/GUARDIAN/POWER OF ATTORNEY HAD BEEN ADVISED

1. EMS explained the potential known and unknown problems including, but not limited to:

_____

_____

*Patient is able to verbalize understanding of their clinical situation. ☐ Yes ☐ No *If **No** is marked Medical Control needs to be contacted.*

2. EMS explained potential for fatal or permanently disabling consequences including, but not limited to:

_____

_____

*Patient is able to verbalize understanding of risks. ☐ Yes ☐ No *If **No** is marked Medical Control needs to be contacted.*

☐ Advised patient to seek care with an Emergency Department or physician as soon as possible.
☐ Advised the patient to call 9-1-1 or their local EMS if their condition changes or they change their mind regarding care and transport.

3. What is the patient's plan to seek further medical evaluation?_____

SECTION D: PATIENT SIGNATURE *(This section to be completed by the patient or patient representative)*

I (we), the undersigned, hereby certify that I (we) refuse ☐ **recommended treatment** and/or ☐ **ambulance transportation** to the appropriate hospital emergency department for ☐ **myself** ☐ **minor less than 18** or ☐ **Other:**_____.
I (we) having been so advised by Prehospital Medical Personnel that treatment or transportation is recommended, hereby accept all responsibility connected with my (our) refusal and release the EMS Provider Agency, their employees, medical personnel, administrative and executive officers from any and all liability or claims resulting from any such refusal of treatment and/or transportation. **Instruction form provided to patient ☐ YES ☐ NO**

SIGNATURE	PRINTED NAME	DATE
PATIENT OR REPRESENTATIVE		
WITNESS		
EMT/PARAMEDIC		

PATIENT DECISION MAKING CAPACITY CHECKLIST

Brief Mental Capacity Evaluation			
Item	**Score**		
	# of Errors	**x (Weight)**	**= (Total)**
What year is it now?	**0 or 1**	**x4**	=_____
What month is it?	**0 or 1**	**x3**	=_____
Present memory phrase: Ask the patient to repeat the phrase and remember it. **"John Brown, 42 Main St Peoria"**			
About what time is it currently? *(Answer correct if within 1 hour)*	**0 or 1**	**x3**	=_____
*Count backwards from 20 to 1	**0, 1, or 2**	**x2**	=_____
*Say the months of the year backwards	**0, 1, or 2**	**x2**	=_____
Repeat the memory phrase. *(each of the underlined portions is worth 1 point)*	**0, 1, 2, 3, 4, 5**	**x2**	=_____
**** Note that although it is possible to make more than two errors when counting backwards from 20 to 1 or saying to months in reverse, the maximum number of points given would be 4 in each case.***	**Final score is equal to the sum of the totals**		=_____
	A score of 0 to 8 indicates normal capacity A score of 9 to 19 indicates mildly impaired capacity A score of 20 to 28 indicates severely impaired capacity		

Potential Signs and Symptoms of Patient Intoxication	Remember Some Conditions Can Mimic Intoxication
• Impairment of reasoning and memory	• Infections
• Exaggerated behavior and intensified emotions	• Respiratory disease, hypoxia
• Slurred speech	• Head injury, subdural hematoma
• Impairment of motor coordination	• Diabetes, hypoglycemia
• Reduced judgment and self-control	• Epilepsy (temporal lobe), post-ictal
• Rapid movement of eyes to one side (nystagmus)	• Meningitis
• Unsteady gait	• CVA or TIA

NOTES:_____