

Emergency Medical Services (EMS) Patient Discharge Information

PCR Number

Patients name	Date of Birth	Date
Patients Address	Phone	EMS Professionals Name No

PATIENT REFUSAL	<input type="checkbox"/>	This section only applies if this box is marked	
	<p>The Paramedic has recommended:</p> <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Measuring the patient's blood pressure <input type="checkbox"/> A backboard and neck collar for the patient <input type="checkbox"/> Ambulance transportation for the patient </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> A complete physical exam of the patient <input type="checkbox"/> Giving the patient oxygen <input type="checkbox"/> Starting an IV for the patient <input type="checkbox"/> Giving the patient medicine _____ <input type="checkbox"/> Other _____ </td> </tr> </table> <p>I refuse the care that the Paramedic has recommended. I understand that my refusal may result in serious injury or death to the patient. I accept full responsibility for this decision. I assume all risks and consequences resulting from my refusal of care. I will not hold the EMS service or its officers, agents, or employees responsible for any bad things that happen to the patient because of my refusal.</p> <p>My signature below attests that I understand what has been recommended, what the consequences may be if that is not done, and still refuse to have recommended care provided by the EMS service.</p>		<input type="checkbox"/> Measuring the patient's blood pressure <input type="checkbox"/> A backboard and neck collar for the patient <input type="checkbox"/> Ambulance transportation for the patient
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PATIENT INSTRUCTIONS	<input type="checkbox"/>	This section only applies if this box is marked				
	<p>You have not been evaluated by a doctor.</p> <p>You should contact or see your doctor immediately.</p> <p>The patient is being released to:</p> <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Family member <input type="checkbox"/> Guardian </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Laws Enforcement Officer <input type="checkbox"/> Other: _____ </td> </tr> </table> <p>Follow the instructions (printed on the back of this form) indicated:</p> <table style="width: 100%;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Head Injury <input type="checkbox"/> Extremity Injury </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Back Pain <input type="checkbox"/> Insect Bite/Sting <input type="checkbox"/> Vomiting / Diarrhea </td> <td style="width: 33%; vertical-align: top;"> <input checked="" type="checkbox"/> Universal <input type="checkbox"/> Fever <input type="checkbox"/> Respiratory Distress <input type="checkbox"/> Wound Care </td> </tr> </table> <p>Other instructions:</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>		<input type="checkbox"/> Family member <input type="checkbox"/> Guardian	<input type="checkbox"/> Laws Enforcement Officer <input type="checkbox"/> Other: _____	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Head Injury <input type="checkbox"/> Extremity Injury	<input type="checkbox"/> Back Pain <input type="checkbox"/> Insect Bite/Sting <input type="checkbox"/> Vomiting / Diarrhea
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Guardian's name (printed)	<input type="checkbox"/> Patient	Patient / Guardian Signature	
Guardian's address <input type="checkbox"/> Same as Patient	<input type="checkbox"/> Guardian <input type="checkbox"/> Refused to Sign	Date of Signature	EMS Personnel's Signature
Witness Signature	Witness Signature	Patient's Physician Name / Phone Number	
LEO on Scene	Agency	I have contacted Dr. _____ @ <input type="checkbox"/> OMH <input type="checkbox"/> Naval Hospital. Informed him/her of this call and he/she: <input type="checkbox"/> Concurs <input type="checkbox"/> Disagrees (Explain on Call Report) <input type="checkbox"/> Offered No Direction	