SAN JUAN ISLAND EMS SUPPLEMENTAL REPORT FOR PATIENT NON-TRANSPORT

EMS PROFESSIONAL

Date: _____ Time: _____ Run #: _____
Patient Name: _____ Gender: M or F
Incident Address: _____
Patient Age: _____ (If <18 years of age, is guardian at scene? _____ YES _____ NO)

Does situation involve: _____ *Chest Pain _____ *SOB _____ Head Injury _____ +Altered LOC

_____ Poss. Intoxication _____ +Diabetes _____ Motor Vehicle Crash
* If Chest Pain or SOB: Pulse Ox _____ Monitor: Rate _____ Rhythm _____
+ If altered LOC or Diabetes: Dstick #1 _____ Dstick #2 _____ (if applicable)
If treatment administered, have symptoms resolved: _____ YES _____ NO

Patient is alert and oriented to person, place, time, and situation (A+Ox4): _____ YES _____ NO

Pulse: _____

HR	0	50	75	100	125	150	175	200

BP: _____/_____

Systolic BP	0	75	100	125	150	175	200	225

RR: _____

Resting Resp. Rate	0	12	16	20	24	28	32	36

Patient REFUSES or is uncooperative with vital signs or physical exam. _____

Patient appears to understand clinical situation: _____ YES _____ NO
Risk(s) of NO TRANSPORT have been explained to patient: _____ YES _____ NO
MEDICAL CONTROL HAS BEEN CONTACTED _____ YES _____ NO (Always required)

REASON FOR NO TRANSPORT:

_____ Patient refuses transport to appropriate medical facility by EMS against EMS professional's advice.
_____ Patient does not desire transport to appropriate medical facility via EMS; EMS professional believes alternative treatment/transport plan is acceptable.
_____ Patient does not believe transport by EMS is necessary/indicated; EMS professional agrees.

PATIENT

- I understand that I have NOT been evaluated by a medical doctor and that ***I may have undermined injuries or illnesses that could pose a threat to my life, health, safety, and medical condition.***
- I understand that I may, at any time, reconsider this course of action and request transport by EMS to go to an appropriate medical facility to receive an evaluation and medical services.
- I understand the possible consequences of my decision to refuse treatment and or transport. I assume full responsibility for my decision to not be treated and or transported to an appropriate medical facility and hereby release the EMS, its personnel, employees, volunteers, and staff from all claims resulting frm my voluntary refusal of treatment and or transport.

_____ _____
Signature of Patient/Guardian (relationship) Witness of Signature

_____
EMS Professional's Signature