Maryland Institute for
Emergency Medical Services Systems

Short Form Patient Information Sheet

Jurisdiction: ______________________ **Date:** ____________
Incident # ____________________ **Time Arrived at Hospital:** __________
Unit #: ____________________
Age: ________ **DOB:** ________ **Wt:** _____ **Kg** **Gender:** ❑M ❑F
Priority: ❑ 1 ❑ 2 ❑ 3 ❑ 4 **Trauma Category:** ❑ A ❑ B ❑ C ❑ D
Patient's Name: ______________________________________
Patient's Address: ______________________________________
City: ______________________ **State:** __________
Point of Contact: ____________________ **Phone Number:** __________
Chief Complaint: ______________________________________
Time of Onset: ________ **Past Medical History: (DNR/MOLST ❑ A1 ❑A2 ❑B)**
Cardiac ❑ **CHF** ❑ **Hypertension** ❑ **Seizure** ❑ **Diabetes** ❑ **COPD** ❑ **Asthma** ❑
Other: ______________________________________
Current Meds: ________ ________ ________ ________
________ ________ ________ ________ ________
Allergies: Latex ❑ **Penicillin/Ceph** ❑ **Sulfa** ❑ **Other:** __________

Assessments

Vitals
Time: __________
Temperature __________
B/P: ______ / ______
Pulse: __________
Respirations: __________
SAO2: __________%
Capnography: __________
Carbon Monoxide: __________

Repeat Vitals
Time: __________
B/P: ______ / ______
Pulse: __________
Respirations: __________
SAO2: __________%
Capnography: __________
Carbon Monoxide: __________

Respiration

Left		Right
❑	Clear	❑
❑	Rales	❑
❑	Labored	❑
❑	Stridor	❑
❑	Rhonchi	❑
❑	Wheezes	❑
❑	Decreased	❑
❑	Agonal	❑
❑	Absent	❑

Skin
❑ Warm
❑ Hot
❑ Cool
❑ Dry
❑ Clammy
❑ Diaphoretic
❑ Cyanotic

GCS
Eyes (4): ______
Motor (6): ______
Verbal (5): ______
TOTAL: ______

Pupils
❑ PERRL
❑ Unequal
❑ Fixed/Dilated

Pulse
❑ Regular ❑ Irregular
❑ JVD ❑ Peripheral Edema
Cap Refill: ________ seconds

Neuro
❑ A ❑ V
❑ P ❑ U

Assessment

Procedures

Cardiac Rhythm:
____

Perform 12 Lead Yes ❑ No ❑12
Lead Transmit Yes ❑ No ❑

Glucometer:
____

❑IV1 ❑IV2 Time Started ______
❑IO ❑EJ
Amount Infused:
____

CPR Performed Yes ❑ No ❑
ROSC Yes ❑ No ❑
Induced Hypothermia Yes ❑ No ❑

Cincinnati Stroke Scale
Normal/Abnormal
Facial Droop Normal ❑ Abnormal ❑
Arm Drift Normal ❑ Abnormal ❑
Speech Normal ❑ Abnormal ❑
Last Known Well Time/Date: __________

Los Angeles Motor Scale (LAMS)

Facial Droop		*Grip Strength*	
Absent	0	Normal	0
Present	1	Weak Grip	1
		No Grip	2

Arm Drift	
Absent	0
Drifts Down	1
Falls Rapidly	2

Score: ______

Oxygen
❑ NRB Mask ❑ King Airway
❑ Nasal Cannula ❑ CPAP
❑ NPA/OPA ❑ NDT
❑ BVM ❑ Ventilator
❑ ET ❑ NT ❑ NGT
❑ Easy Tube

Treatment:

Jurisdictional Additions:

Patient Signature **Social Security Number**

Receiving Facility Representative Signature and Printed Name:

Print Clinician Name: ______________________

Entered in ePCR

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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 - 4) 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

High 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. High Risk chief complaint (I.E. 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

If yes, consult

10. Provider impression is that the patient requires hospital evaluation 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 the Montgomery County, MD Fire and Rescue Service 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:

Attempted to convince patient

Attempted 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 #: Clinician Name: Time: