



Short Form Patient Information Sheet 2016

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: _____ B/P: _____ / _____ Pulse: _____ Respirations: _____ SAO2: _____ % Capnography: _____ Carbon Monoxide: _____ Repeat Vitals Time: _____ B/P: _____ / _____ Pulse: _____ Respirations: _____ SAO2: _____ % Capnography: _____ Carbon Monoxide: _____	Respiration <table border="1"> <tr> <th>Left</th> <th>Right</th> </tr> <tr> <td><input type="checkbox"/> Clear</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Rales</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Labored</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Stridor</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Rhonchi</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Wheezes</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Decreased</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Agonal</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Absent</td> <td><input type="checkbox"/></td> </tr> </table>	Left	Right	<input type="checkbox"/> Clear	<input type="checkbox"/>	<input type="checkbox"/> Rales	<input type="checkbox"/>	<input type="checkbox"/> Labored	<input type="checkbox"/>	<input type="checkbox"/> Stridor	<input type="checkbox"/>	<input type="checkbox"/> Rhonchi	<input type="checkbox"/>	<input type="checkbox"/> Wheezes	<input type="checkbox"/>	<input type="checkbox"/> Decreased	<input type="checkbox"/>	<input type="checkbox"/> Agonal	<input type="checkbox"/>	<input type="checkbox"/> Absent	<input type="checkbox"/>	Skin <input type="checkbox"/> Warm <input type="checkbox"/> Hot <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Clammy <input type="checkbox"/> Diaphoretic <input type="checkbox"/> Cyanotic	GCS Eyes (4): _____ Motor (6): _____ Verbal (5): _____ TOTAL: _____ Pupils <input type="checkbox"/> PERRL <input type="checkbox"/> Unequal <input type="checkbox"/> Fixed/Dilated
	Left	Right																					
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<input type="checkbox"/> Absent	<input type="checkbox"/>																						
Pulse <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> JVD <input type="checkbox"/> Peripheral Edema Cap Refill: _____ seconds	Neuro <input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> P <input type="checkbox"/> U																						

Assessment

Procedures

Cardiac Rhythm: _____ Perform 12 Lead Yes <input type="checkbox"/> No <input type="checkbox"/> 12 Lead Transmit Yes <input type="checkbox"/> No <input type="checkbox"/> Glucometer: _____ <input type="checkbox"/> IV1 <input type="checkbox"/> IV2 <input type="checkbox"/> IO <input type="checkbox"/> EJ Amount Infused: _____	Cincinnati Stroke Scale <i>Normal/Abnormal</i> Facial Droop Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Arm Drift Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Speech Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Last Known Well Time/Date: _____																												
CPR Performed Yes <input type="checkbox"/> No <input type="checkbox"/> ROSC Yes <input type="checkbox"/> No <input type="checkbox"/> Induced Hypothermia Yes <input type="checkbox"/> No <input type="checkbox"/>	Los Angeles Motor Scale (LAMS) <table border="1"> <tr> <th><i>Facial Droop</i></th> <th></th> <th><i>Grip Strength</i></th> <th></th> </tr> <tr> <td>Absent</td> <td>0</td> <td>Normal</td> <td>0</td> </tr> <tr> <td>Present</td> <td>1</td> <td>Weak Grip</td> <td>1</td> </tr> <tr> <td><i>Arm Drift</i></td> <td></td> <td>No Grip</td> <td>2</td> </tr> <tr> <td>Absent</td> <td>0</td> <td></td> <td></td> </tr> <tr> <td>Drifts Down</td> <td>1</td> <td></td> <td></td> </tr> <tr> <td>Falls Rapidly</td> <td>2</td> <td>Score:</td> <td>_____</td> </tr> </table>	<i>Facial Droop</i>		<i>Grip Strength</i>		Absent	0	Normal	0	Present	1	Weak Grip	1	<i>Arm Drift</i>		No Grip	2	Absent	0			Drifts Down	1			Falls Rapidly	2	Score:	_____
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	Oxygen <input type="checkbox"/> NRB Mask <input type="checkbox"/> King Airway <input type="checkbox"/> Nasal Cannula <input type="checkbox"/> CPAP <input type="checkbox"/> NPA/OPA <input type="checkbox"/> NDT <input type="checkbox"/> BVM <input type="checkbox"/> Ventilator <input type="checkbox"/> ET <input type="checkbox"/> NT <input type="checkbox"/> NGT <input type="checkbox"/> Easy Tube																												

Treatment:

Jurisdictional Additions:

_____ Patient Signature

_____ Patient SSN

_____ Receiving Facility Representative Signature and Printed Name

Print Provider Name: _____
 _____ Entered in ePCR (check)

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? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | | Place? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | | Time? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | | Situation? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | 2. Altered level of consciousness? | | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | 3. Alcohol or drug ingestion by history or exam with: | | | |
| | a. Slurred speech? | | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | b. Unsteady gait? | | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | 4. Patient does not understand the nature of illness and potential for bad outcome? | | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | | | If yes, transport | |
| At Risk
Criteria | 5. Abnormal vital signs | | | |
| | For Adults | | | |
| | Pulse greater than 120 or less than 60? | | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | Systolic BP less than 90? | | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | Respirations greater than 30 or less than 10? | | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | For minor/pediatric patients | | | |
| | Age inappropriate HR or | | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | Age inappropriate RR or | | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | Age inappropriate BP | | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| | 6. Serious chief complaint (chest pain, SOB, syncope) | | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 7. Head Injury with history of loss of consciousness? | | <input type="checkbox"/> yes | <input type="checkbox"/> no | |
| 8. Significant MOI or high suspicion of injury | | <input type="checkbox"/> yes | <input type="checkbox"/> no | |
| 9. For minor/pediatric patients: ALTE, significant past medical history, or suspected intentional injury | | <input type="checkbox"/> yes | <input type="checkbox"/> no | |
| 10. Provider impression is that the patient requires hospital evaluation | | If yes, consult | | |
| | | <input type="checkbox"/> yes | <input type="checkbox"/> 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:

- Attempt to convince patient Attempt 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 #: _____ Provider Name/EID: _____ Time: _____