**Austin/Travis County EMS System Incident Notes and/or Patient Refusal**

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| **Incident Date:** | **Incident** # | | **Incident/Patient Address:** | | | | **Chief Complaint:** | | | |
| **Patient Name:** | | | | | **DOB:** | | **Age:** | **Weight:** | | **Gender: M / F** |
| **Medical Hx:** □ Denies □ ACS □ Stroke □ CHF □ Asthma □ HTN □ Seizure □ Diabetes □ Dialysis **Other:** | | | | | | | | | | |
| **Medications:** | | | | | | | | | | |
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| **Allergies:** | | | | | | | | | | |
| **Events preceding incident:** | | | | | | | | | | |
| **Last Oral Intake:** | | | | | | | | | | |
| **□ Trauma Activation** | | **□ Resuscitation Alert** | | **□ Stroke Alert** | | **□ CPR** | **□ DNR** | | **□ Obvious DOS** | |

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| **Airway** | **□** OPA | **□** NPA | **□** FBAO Removal | | **□** BIAD Insertion | | **□** Suction | | **□** Positioning |
| **Breathing** | **□** BVM | **□** CPAP | **□** NRB | | **□** Nasal Cannula | | **□** ETCO2 | **□** SpO2 | **□** Albuterol Neb |
| **Circulation** | **□** CPR | | **□** AED | **□** 12 Lead | **□** NTG | **□** IV/IO | **□** Hemorrhage Control | | |
| **□** LUCAS | | **□** ITD | **□** ASA | **□** EPI Pen | **□** Tourniquet | | | |
| **Disability** | □ SMR (See Table) | | □ CPSS (See Table) | | □ Glucose Assessment: | | | | |

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| **Time (24 Hr)** |  |  |  |  |  |  | **Glascow Coma Scale** | | |  | **Cincinnati Stroke Scale** | | | | |
| **Mental Status (A-V-P-U)** |  |  |  |  |  |  | **Eyes** | 1 | None |  | **Facial Droop** | Normal | | Abnormal | |
| 2 | To Pain |  | **Arm Drift** | Normal | | Abnormal | |
| **GCS** |  |  |  |  |  |  | 3 | To Voice |  | **Speech** | Normal | | Abnormal | |
| 4 | Spontaneous |  |  | | | | |
| **Heart Rate** |  |  |  |  |  |  |  |  | |  | **Pupils** | | | | |
| **Verbal** | 1 | None |
| **Blood Pressure** |  |  |  |  |  |  | 2 | Incoherent |  | Not Assessed | | Midrange | | |
| 3 | Inappropriate |  | Equal | | Unequal | | |
| **Respiratory Rate ( BVM Rate)** |  |  |  |  |  |  | 4 | Confused |  | Reactive | | Non-reactive | | |
| 5 | Oriented |  | Pinpoint | | Dilated | | |
| **O2 Sat (SPO2)** |  |  |  |  |  |  |  |  | |  | **Spinal Motion Restriction** | | | | |
| **Motor** | 1 | None |
| **Temp** (**O**ral/**A**xillary/**R**ectal?) |  |  |  |  |  |  | 2 | Extension |  | **C-Spine Restricted** | | | Yes | No |
| 3 | Flexion |  | **Unreliable Patient** | | | Yes | No |
| **BGL** |  |  |  |  |  |  | 4 | Withdraws |  | **Distracting Injury** | | | Yes | No |
| 5 | Localizes |  | **Spine Pain** | | | Yes | No |
|  |  |  |  |  |  |  | 6 | Obeys |  | **Abnormal Sens/Motor** | | | Yes | No |
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| **OB/Emergent Delivery/APGAR** | | | | | | | | |  | **Lung Sounds** | | |  | X= | Abrasion |
| Gestation in Weeks: | | | | **APGAR** | | | | |  |  | C= | Clear |  | B= | Bruise |
| LMP: | | | |  | **0** | | **1** | **2** | A= | Absent |  | L= | Laceration |
| Due Date: | | | | **HR** | None | | <100 | >100 | D= | Diminished |  | S= | Stab |
| G: | P: | AB: | | **RR** | None | | Slow/Weak | Strong | W= | Wheezing | G | GSW |
| Prenatal: Y / N / UNK | | | | **Tone** | None | | Weak | Active | RH= | Rhonchi | BN= | Burn |
| OB Dr. | | | | **Reflex** | None | | Weak | Vigorous | S= | Stridor | P= | Pain |
| Delivery Time: | | | | **Color** | Blue | | Pink Core | All Pink | R= | Rales | FX= | Fracture |
| Meconium Stain: | | | Y / N |  | | **Heart Rate** | | **APGAR** | UA= | Unable to Auscultate | AMP= | Amputation |
| Suctioning: | | | Y / N | 1 min | |  | |  |  | | | | | | |
| 5 min | |  | |  |

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| **Notes:** | |
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| **Agency & Unit ID #:** | |
| **Lead Care Provider: Name & ID #:** | **Agency & Unit ID #:** |

**Determination of Decision-Making Capacity**

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| Patient is able to express in their own words the following: | **YES** | **NO** |
| An understanding of the nature of their illness | **YES** | **NO** |
| An understanding of the risks of refusal including death | **YES** | **NO** |
| Pt. can provide rationale for refusal and debate this rationale | **YES** | **NO** |
| **A patient with any of the following MAY lack decision-making capacity and should be carefully assessed for their ability to perform the above** | | |
| Orientation to person, place or time that differs from baseline | **YES** | **NO** |
| History of drug/alcohol ingestion with appreciable impairment such as slurred speech or unsteady gait | **YES** | **NO** |
| Head injury with LOC, amnesia, repetitive questioning | **YES** | **NO** |
| Medical condition such as hypovolemia, hypoxia, metabolic emergencies (e.g., diabetic issues), hyporthermia | **YES** | **NO** |
| If any question exists about their capacity, contact Medical Control | **YES** | **NO** |

**Refusal of Care/Treatment Checklist**

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| Pt. ≥ 18 or emancipated minor | **YES** | **NO** |
| Pt. demonstrates capacity (from above) | **YES** | **NO** |
| Solutions to obstacles have been sought | **YES** | **NO** |
| Pt. instructed to call back at any time | **YES** | **NO** |
| Pt. is not suicidal/homicidal | **YES** | **NO** |
| Pt. understands evaluation is incomplete | **YES** | **NO** |
| Pt. instructed to seek medical attention | **YES** | **NO** |
| Above documented fully in PCR | **YES** | **NO** |
| **In the following high risk situations, contact with Medical Control is recommended:** | | |
| Age greater than 65? | **YES** | **NO** |
| Systolic BP greater than 200 or less than 90? | **YES** | **NO** |
| Serious chief complaint (chest pain, SOB, syncope)? | **YES** | **NO** |
| Pulse greater than 110 or less than 60? | **YES** | **NO** |
| Respirations greater than 30 or less than 12? | **YES** | **NO** |
| Significant MOI or high suspicion of injury? | **YES** | **NO** |
| If it is your impression that the patient requires hospital evaluation? | **YES** | **NO** |

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| **Statement of Refusal – To be completed by patient or patient representative** | | | |
| ❒ I (we), acknowledge having been advised by the Emergency Medical Services (EMS) Providers that described treatment(s) and/or transportation is recommended and that significant risk(s) could be involved with refusal of EMS treatment and/or transportation, including, but not limited to; exacerbation of present complaint / condition / injuries, or the possibility of significant disability and/or death occurring from refusal of emergency medical care or transportation. | | | |
| ❒I (we), hereby certify that I (we) refuse ❒ recommended examination or treatment and/or ❒ ambulance / air transportation to the closest appropriate hospital emergency department for: ❒myself ❒minor less than 18 ❒ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to preserve life/limb or promote recovery of health. I (we) hereby accept all responsibility connected with this refusal and release TDSHS FRO#\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and/or ESD#\_\_\_\_\_\_\_, their respective officials, employees and first responders, the City of Austin, and their respective employees, officials, and Medical Director, from any and all liability or claims resulting from any such refusal of advised examination, care and/or transportation.  ***I understand that I should immediately contact the EMS system via 911 (or appropriate emergency number if no 911 system is available), my personal physician, or emergency department physician should further medical care be required.*** | | | |
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| **Person or Representative – Signature** | **Person or Representative – Print** | **Person or Representative Date of Birth** | **Date** |

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| **Witness Signatures** | | **Section 1 required for all Refusals / Sections 1 and 2 required for patients deemed competent but refusing to sign form** | | |
| **Section 1** |  | | | |
| **Witness – Signature (Must be of legal age)** | | **Witness – Print** | **Date** |
| **Section 2** |  | | | |
| **Responder – Signature** | | **Responder – Print** | **Date** |