

**LENOX AMBULANCE SERVICE**  
**“INFORMED DECISION-MAKING” FORM – Version 1.4**

**PATIENT ASSESSMENT**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**(A) LEGAL CAPACITY**

**NOTE: If answer to at least one of the questions in this section is "YES," the patient may sign this form. If "NO" to all, signature of legally authorized decisionmaker required.**

Patient over 18? Yes \_\_\_ No \_\_\_      If minor, is patient married? Yes \_\_\_ No \_\_\_      If minor, is patient pregnant? Yes \_\_\_ No \_\_\_

Comments/Quotes/Observations: \_\_\_\_\_

**(B) MENTAL CAPACITY**

**NOTE: If "YES" to any question in (B), Patient may lack capacity to refuse care, though this is a fact-specific determination and consultation with medical command is encouraged. Do not release Patient or allow to sign Form unless explanation noted or, if Patient is less than 18 years of age, the Form is signed by Parent or legal guardian.**

Disoriented to:    Person? Yes \_\_\_ No \_\_\_    Possible ETOH/drug use? Yes \_\_\_ No \_\_\_    Odor of ETOH? Yes \_\_\_ No \_\_\_  
                          Place? Yes \_\_\_ No \_\_\_    Admitted by Patient? Yes \_\_\_ No \_\_\_    Unsteady gait? Yes \_\_\_ No \_\_\_  
                          Time? Yes \_\_\_ No \_\_\_    Slurred speech? Yes \_\_\_ No \_\_\_

Comments/Quotes/Observations: \_\_\_\_\_

**(C) MEDICAL CAPACITY**

**NOTE: If "YES" to any question in (C), Patient may lack capacity to refuse care, though this is a fact-specific determination and consultation with medical command is encouraged. Do not release Patient or allow to sign Form unless explanation noted or, if Patient is less than 18 years of age, the Form is signed by Parent or legal guardian.**

Head injury? Yes \_\_\_ No \_\_\_    AMS or ALOC? Yes \_\_\_ No \_\_\_    Abnormal glucose? Yes \_\_\_ No \_\_\_    READING: \_\_\_\_\_  
Abnormal pupils? Yes \_\_\_ No \_\_\_    Severe SOB? Yes \_\_\_ No \_\_\_    Abnormal SpO2? Yes \_\_\_ No \_\_\_    READING: \_\_\_\_\_  
Comments/Quotes/Observations: \_\_\_\_\_

**(D) MEDICAL COMMAND** Physician name: \_\_\_\_\_    Contacted by: phone \_\_\_\_\_ radio \_\_\_\_\_ on scene \_\_\_\_\_  
Orders: Release Patient \_\_\_\_\_    Use Reasonable Force/Restraint to Treat \_\_\_\_\_    Transport \_\_\_\_\_

Comments/Quotes/Observations: \_\_\_\_\_

**(E) DESTINATION/DIVERT**      Diverted by: \_\_\_\_\_      Diverted to: \_\_\_\_\_  
Reason: \_\_\_\_\_

Destination instructions voiced by patient: \_\_\_\_\_

**(F) PROVIDER SIGNATURE** Crew Member Signature \_\_\_\_\_ Cert. #. \_\_\_\_\_

**PATIENT ADVICE**

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

This form is being provided to me because I have: (check all that apply)

- REFUSED ASSESSMENT       REFUSED TREATMENT       REFUSED TRANSPORT
- INSISTED ON BEING TRANSPORTED TO A HOSPITAL OTHER THAN THAT WHICH THE EMS PERSONNEL RECOMMEND

I understand that the EMS personnel are not physicians and are not qualified or authorized to make a diagnosis and that their care is not a substitute for that of a physician. I recognize that I may have a serious injury or illness which could get worse without medical attention even though I (or the patient on whose behalf I legally sign this document) may feel fine at the present time.

I understand that I may change my mind and call 9-1-1 if treatment or assistance is needed later. I also understand that treatment is available at an emergency department 24 hours a day or from my physician. If I have insisted on being transported to a destination other than that recommended by the EMS personnel, I understand and have been informed that there may be a significant delay in receiving care at the emergency room, that the emergency room may lack the staff, equipment, beds or resources to care for me promptly, and/or that I might not be able to be admitted to that hospital.

I acknowledge that this advice has been explained to me by the ambulance crew and that I have read this form completely and understand its provisions. I agree, on my own behalf (and on behalf of the patient for whom I legally sign this document), to release, indemnify and hold harmless the Lenox Ambulance Service and its officers, members, employees or other agents, and the medical control designee or physician and medical control facility, from any and all claims, actions, causes of action, damages, or legal liabilities of any kind arising out of my decision, or from any act or omission of the ambulance service or its crew, or the medical command physician or medical command facility.

I acknowledge receipt of the ambulance service's Notice of Privacy Practices. I acknowledge that insurance will not cover any charges incurred, and that I may be billed for this EMS response.

*OTHER SPECIFIC INSTRUCTIONS TO PATIENT:* \_\_\_\_\_

\_\_\_\_\_

Signature of: Patient  Parent  Legal Guardian

\_\_\_\_\_ Date

\_\_\_\_\_ Witness Signature

**IF PATIENT REFUSES TO SIGN:** I attest that the patient has refused care and/or transportation by the emergency medical services providers. The patient was informed of the risks of this refusal and refused to sign this form when asked by the EMS providers.

\_\_\_\_\_ Witness Signature

\_\_\_\_\_ Print Name