### ABDOMINAL PAIN:
- Loss of appetite or nausea
- Vomiting or diarrhea
- Aching or cramping
- Swelling in the abdomen
- Persistent cramping

### BACK & NECK PAIN:
- Pain or stiffness in the neck, upper back, or lower back
- Trouble standing or walking
- Difficulty using one or both arms or legs

### DIABETIC FOOT:
- Swelling, redness, or warmth in the feet
- Ulcers or open sores on the feet
- Change in the color or temperature of the feet
- Increased or decreased feeling in the feet

### DIABETES:
- Little or no urine
- Excessive thirst
- Frequent urination
- Unexpected weight loss

### HEAD INJURY:
- Drowsiness
- Confusion
- Inability to speak
- Loss of memory
- Blurred vision

### RESPIRATORY DISTRESS:
- Shortness of breath
- Rapid breathing
- Trouble breathing
- Coughing up blood
- Skin color that is blue or gray

### SEIZURE:
- All of a sudden, loss of consciousness
- Convulsions
- Jerking body movements
- Confusion

### EXTREMITY INJURY:
- Swelling
- Bruising
- Pain
- Redness
- Coldness

### VOMITING/DIARRHEA/FEVER:
- Nausea
- Vomiting
- Diarrhea

### WOUND CARE:
- Ulcers
- Open sores
- Infection

### PATIENT RIGHTS:
- You have the right to receive a copy of the Notice of Privacy Practices upon request.
- You have the right to request that we restrict how your health information is used and disclosed.
- You have the right to request that your medical information be amended.
- You have the right to an accounting of certain disclosures of your health information.
- You have the right to request that your medical information not be transferred to another provider.
**REFUSAL OF EMERGENCY MEDICAL SERVICES & Release – Receipt of Notice of Privacy Rights**

**Patient Name:** __________________________   **Relationship:** ________________

**Birth Date:** ___________   **Call Date:** ___________

**Address:** ___________________________   **City:** _______________   **State:** ___________   **Zip:** ___________

**Location of Call:** ___________________________   **Report #: ___________   **Dispatch Time:** _________

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**V. EMS Cognitive Evaluation**

*Each section is optional as outlined in Refusal Procedural Guideline*

**Max Score is 9**

1. What SEASON is it?  
2. What YEAR is it?  
3. What MONTH is it?  
4. What DAY is it?  
5. What is the DATE?  
6. What COUNTRY are we in?  
7. What STATE are we in?  
8. What CITY are we in?  
9. Where are we RIGHT NOW?

**Max Score is 3**

1. Say "ball", "flag", "tree" clearly and slowly, about one second for each, then ask the patient to repeat them.  
2. Check the box for each correct response. The first repetition determines the score.  
3. If he/she does not repeat all three correctly, keep saying them up to 3 tries until he/she can repeat them.

**Max Score is 9**

1. What is the tree?  
2. What is the flag?  
3. What is the ball?  
4. What season is it?  
5. What country are we in?  
6. What state are we in?  
7. What month is it?  
8. What day is it?  
9. What is the date?

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1. **Instruct the patient to copy the design below in the space provided at the right.**

2. **Instruct the patient to write a sentence.**

3. **Show the patient your uniform badge and ask him/her what it is.  Repeat for a pencil/pen.**

4. **Instruct the patient to spell the word "WORLD" backwards.**

5. **Instruct the patient to recall the three words you previously asked him/her to remember.**

6. **If he/she does not repeat all three correctly, keep saying them up to 3 tries until he/she can repeat them.**

**Max Score is 3**

1. **Altered Mental Status**
2. **Initial GCS <10**
3. **Resp. <10 or >29**
4. **Serious MOI**
5. **Serious CC**

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**II. On-Line Medical Control**

*(This section is optional as outlined in the Refusal Procedural Guideline)*

1. **Physician/Designee Name:** __________________________   **Contacted by:**  
2. **Orders:**  
3. **Patient may refuse indicated treatment and/or transport**
4. **Reasonable force and/or restraints to provide indicated treatment and/or transport**
5. **Other**

**III. Patient Advised**

1. **Yes**  
2. **No**

**Max Score is 1**

1. **Medical treatment/evaluation needed**
2. **Ambulance transport needed**
3. **Further harm could result without medical treatment/evaluation**
4. **Transport by means other than ambulance could be hazardous in light of patient’s present illness/injury**
5. **Patient Instructions (backside of form) were discussed and outlined**
6. **Patient or Guardian understands verbalizing of the information on this sheet and the Patient Instructions**

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**IV. Disposition**

1. **Refused ALL EMS Services**
2. **Refused Transport**
3. **Refused Recommended Treatment(s)**
4. **Refused Assessment**
5. **Transported to a facility other than that which EMS Personnel recommended**

**Max Score is 1**

1. **Patient released into care and custody of:**  
2. **Self**
3. **Parent/Guardian**
4. **Relative**
5. **Law Enforcement**
6. **Other**

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**Patient Score**

**Max Score is 9**

**Max Score is 3**

**Max Score is 9**

**Max Score is 3**

**Max Score is 5**

**Max Score is 2**

**Max Score is 2**

**Max Score is 1**

**Max Score is 1**

**Max Score is 1**

**Max Score is 1**

**Max Score is 1**

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**IF PATIENT REFUSES TO SIGN FORM OR COMPLY WITH REFUSAL QUESTIONNAIRE:**

I attest that the patient has refused Assessment, Treatment, and/or Transportation by the Emergency Medical Services providers. The patient, informed of the risks of this refusal, refused to sign this form when asked by the EMS providers.

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**Witness #1**

**Printed Name:** __________________________

**Witness #2**

**Printed Name:** __________________________

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**Medic #1**

**Cert Number:** __________________________

**Medic #2**

**Cert Number:** __________________________

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**DISCLOSURE**

*Based on exams developed by: Folstein MF, Folstein SE, and McHugh PR, 1975*

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**NOTE:** When a single "YES" answer is obtained in Section (I), the patient may lack capacity to refuse care, though this is a fact-specific determination and Section (V) of the Refusal Form should be completed prior to releasing patient and obtaining a signature of refusal. In addition, if there are two (2) or more "YES" answers in Section (I), or EMS Cognitive Evaluation Score of <19, consultation with online medical control is recommended.

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**Printed Name:** __________________________

**Cert. Number:** __________________________