



AUSTIN COUNTY EMERGENCY MEDICAL SERVICES
Informed Decision Making Form

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 in most states. If "NO" to all, signature of legally authorized decision maker 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 ___ ALOC? Yes ___ No ___ Abnormal glucose? Yes ___ No ___ READING: _____
Abnormal pupils? Yes ___ No ___ Severe SOB? Yes ___ No ___ Abnormal SA02? 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 _____ ID. No. _____



PATIENT ADVICE / RELEASE FOR JAIL

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 ambulance service and its officers, members, employees or other agents, and the medical command physician and medical command 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 also acknowledge receipt of the ambulance service's Notice of Privacy Practices.

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

The above patient has been examined by Emergency Medical Services Personal, and has no obvious life threatening medical issues. The above patient has been cleared for jail. In the event that the patient's condition changes or deteriorates, please active the 9-1-1 system for EMS to transport the patient to the hospital.

EMS Crew Member Signature

Print Name