Wise County First Responder Organization

Date: _____

Patient Care Notes

Patient Name: _____
(Last) (First) (Middle)

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____

Age: _____ Date of Birth: _____

Sex: _____ Weight: _____

Past Medical History: _____

Allergies: _____

Medications: _____

_____

_____

Vital Signs

TIME	GCS	B/P	PULSE	RESP	SPO2	TEMP	BGL	APGAR

Skills Performed

Please document the time a skill is performed next to the appropriate field.

Oxygen Therapy: _____ 3-Lead ECG: _____

Defibrillation: _____ 12-Lead ECG: _____

King Airway: _____ IV/IO: _____

Blood Glucose Check: _____

Medication Administered	Time	Route	FRO Personnel Administering Medication

Wise County First Responder Organization

Date: _____

No Treatment and/or Transport
Patient Release of Responsibility

Please use the Patient Care Side of the form to collect Demographic Data

Herein after "the department" shall refer to the following Wise County First Responder Organization that has assumed patient care.

Department Name:_____

	(Patient initials) I have been informed of the reason the department personnel feel that I should go to the emergency center for further evaluation.
	(Patient initials) I have been informed of the evaluation and/or treatment that may/will occur at the Emergency Center.
	(Patient initials) I have been informed of the consequences and/or complications that may result due to my refusal to go to the emergency center for further evaluation.

Have the patient initial ***ONE*** of the following that applies:

	I, the undersigned, have been advised that emergency medical treatment on my/the patient's behalf is necessary, and that refusal of recommended treatment and transport to an emergency center may result in death or imperil my/the patient's health by increasing the opportunity for morbidity. Nevertheless, and understanding all of the above, **I refuse to accept further emergency medical treatment and/or transport to an emergency center,** assume all risks and consequences resulting from my decision and release the department and its members form any and all liability which may occur from my decision to accept their recommendation.
	I accept transport only and refuse all treatment and/or specific treatment which they may render. I have been advised of the possible consequences that may result from the decision not to accept further treatment and release the department and its members from any and all liability which may arise from my decision not to accept their recommendation. (note treatment(s) refused here):
	I have advised the department personnel that I have no injuries/illness at this time and I do not request to be transported to a medical facility for evaluation. I release the department and its members from any and all liability which may occur from my decision.

As a competent adult, I fully understand all of the above, and I am capable of making a rational decision on my behalf.

A. Patient Signature Patient must sign unless physically or mentally incapable If patient cannot sign, Section B or C must bear a signature X	**B. Representative/Witness Signature** Signature on behalf of the patient does not constitute acknowledgement of financial responsibility X
C. Department Personnel Signature Signature indicates that at time of service patient was incapable of signing and no representative or family was present. Signature required only if no signature is obtained in section A or B. X	**Patient did not sign for following reason:** □ Deceased □ Distress level □ In custody □ Language barrier □ Mental status □ Minor/child □ Refused □ Unconscious □ Visually impaired □ Patient care transferred □ Physical impairment of extremities