

ADDRESS: \_\_\_\_\_ (ZIP: \_\_\_\_\_) RELATION: \_\_\_\_\_ )  
 RESPONSIBLE PARTY: \_\_\_\_\_ PHONE ( \_\_\_\_\_ )  
 EMPLOYER'S ADDRESS: \_\_\_\_\_  
 PATIENT'S EMPLOYER: \_\_\_\_\_ PHONE ( \_\_\_\_\_ )  
 WAS THIS A WORKER'S COMPENSATION INJURY:  YES  NO  
 INSURANCE CODE \_\_\_\_\_

INSURANCE ID # \_\_\_\_\_  
 CARRIER \_\_\_\_\_  
 1 MEDICARE  2 MEDICAID  3 CROSS  4 BLUE  5 COMMERCIAL  SELF PAY

**Glasgow Coma Scale**

| Eye Opening   | Verbal Response           | Motor Response                             | Total GCS Score |
|---------------|---------------------------|--|-----------------|
| 4 Spontaneous | 5 Oriented                | 6 Obeys Command                            | 15              |
| 3 To Voice    | 4 Confused                | 5 Localizes Pain                           | 14              |
| 2 To Pain     | 3 Inappropriate Words     | 4 Withdraw (pain)                          | 13              |
| 1 None        | 2 Incomprehensible Sounds | 3 Flexion (pain)                           | 12              |
|               | 1 None                    | 2 Extension (pain)                         | 11              |
|               |                           | 1 None                                     | 10              |
|               |                           | 2 Response to command or painful stimulus. | 9               |

**ICD DIAGNOSTIC CODE**

**Signed:** \_\_\_\_\_  
**Firma:** \_\_\_\_\_  
**Witness:** \_\_\_\_\_  
**Testigo:** \_\_\_\_\_

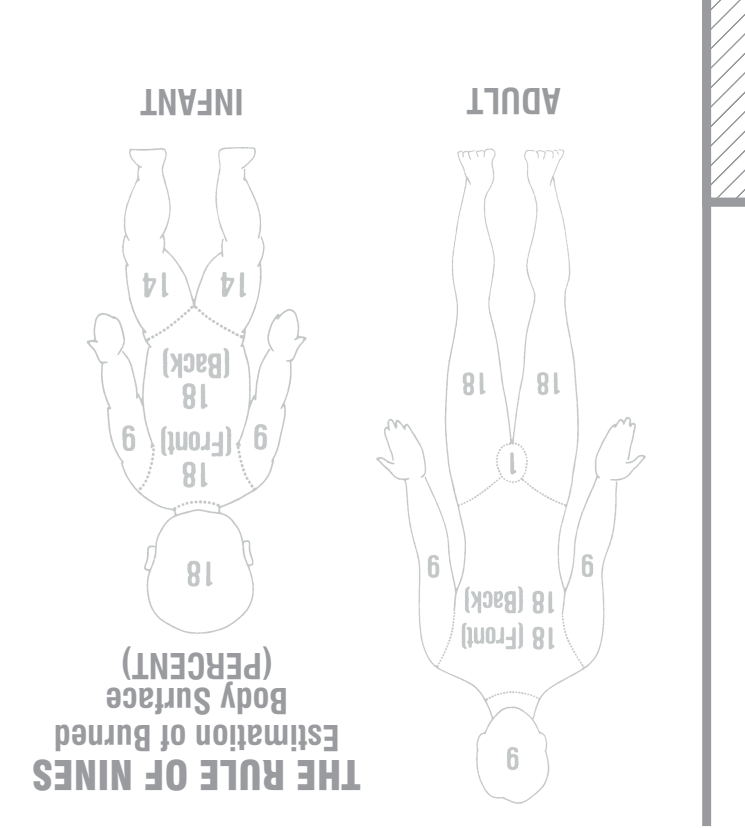
I hereby refuse (treatment/transport to a hospital) and I acknowledge that such treatment/transportation was advised by the ambulance crew or physician. I hereby release such persons from liability for respecting and following my express wishes.

Mediante la presente declaro que me niego a aceptar el tratamiento/traslado a un hospital y reconozco asimismo que el medico o el personal de la ambulancia recomendaron ese tratamiento/traslado. Conscientemente, eximo a dichas personas de toda responsabilidad por haber respetado y cumplido mis deseos expresos.

**REFUSAL OF TREATMENT/TRANSPORTATION**  
 NEGATIVA A RECIBIR TRATAMIENTO/SER TRASLADADO

**RELEASE**

**EXONERACION DE RESPONSABILIDADES**  
 COMPLETE ON WHITE (AGENCY) COPY ONLY  
 LLENE UNICAMENTE LA COPIA BLANCA (DE LA AGENCIA)



Hospital Receiving Agent \_\_\_\_\_  
 (IF REQUIRED)  
 COMPLETE ON WHITE (AGENCY) COPY ONLY

SIGNATURE \_\_\_\_\_

NON-HOSPITAL DISPOSITION CODES:

|     |   |
|-----|---|
| 001 | NURSING HOME                                      |
| 002 | OTHER MEDICAL FACILITY                            |
| 003 | RESIDENCE   |
| 004 | TREATED BY THIS UNIT, TRANSPORTED BY ANOTHER UNIT |
| 005 | REFUSED MEDICAL AID OR TRANSPORT                  |
| 006 | CALL CANCELLED                                    |
| 007 | STANDBY ONLY (NO PATIENT)                         |
| 008 | NO PATIENT FOUND                                  |
| 010 | OTHER   |

