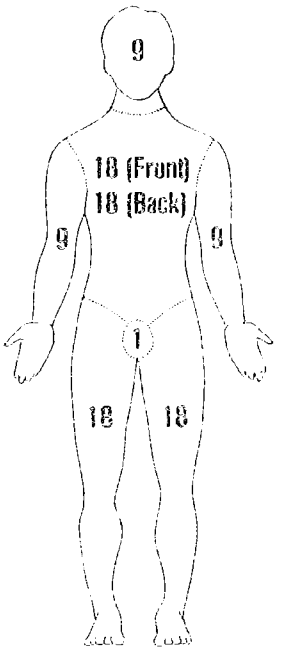
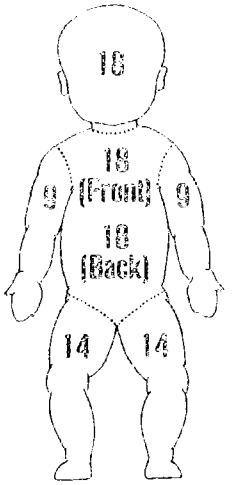
NON-HOSPITAL DISPOSITION CODES:

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



THE RULE OF NINES
Estimation of Burned Body Surface (PERCENT)



ADULT INFANT

Hospital Receiving Agent

(IF REQUIRED)
COMPLETE ON WHITE (AGENCY) COPY ONLY

SIGNATURE

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)

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. Consiguientemente, eximo a dichas personas de toda responsabilidad por haber respetado y cumplido mid deseos expresos.

Signed: _____
Firma:

Witness: _____
Testigo:

Glasgow Coma Scale

Eye Opening	Spontaneous	4	
	To Voice	3	
	To Pain	2	
	None	1	
Verbal Response	Oriented	5	**Patient's Best Verbal Response** Arouse patient with voice or painful stimulus.
	Confused	4	
	Inappropriate Words	3	
	Incomprehensible Sounds	2	
	None	1	
Motor Response	Obeys Command	6	**Patient's Best Motor Response** Response to command or painful stimulus.
	Localizes Pain	5	
	Withdraw (pain)	4	
	Flexion (pain)	3	
	Extension (pain)	2	
	None	1	

Total GCS Score 3-15

ICD DIAGNOSTIC CODE

INSURANCE ID #

CARRIER

1 ☐ MEDICARE 2 ☐ MEDICAID 3 ☐ BLUE CROSS 4 ☐ COMMERCIAL INSURANCE 5 ☐ SELF PAY

WAS THIS A WORKER'S COMPENSATION INJURY: ☐ YES ☐ NO INSURANCE CODE _____

PATIENT'S EMPLOYER: _____ PHONE ( ) _____

EMPLOYER'S ADDRESS: _____

RESPONSIBLE PARTY: _____ PHONE ( ) _____

ADDRESS: _____ (ZIP: _____) RELATION: _____