

SPRINGFIELD FIRE DEPARTMENT

Series 900

Title:	Patients Requesting Limited Services	904
Category:	Emergency Medical Operations	7/2017

MEDICAL CONTROL BOARD GUIDELINE AND PROCEDURE FOR PATIENTS WHO REQUEST LIMITED SERVICE

(This guideline is for reference only and must be approved by local medical control as required by the Department of Public Health P.A. 179 of 1990 amended P.A. 368 of 1978)

OBJECTIVE

The Springfield Fire Department recognizes that some patients, particularly those with terminal illness, may not desire the full spectrum of pre-hospital and emergency medical services available. Given the constraints of emergency medical practice, and given that the pre-hospital provider is neither trained nor qualified to make these decisions that Springfield Fire Department wishes to accommodate and support the needs of these patients and their physicians.

PURPOSE

To provide for special and appropriate limitations in emergency medical care delivery for those patients who desire limited services. This guideline and procedure is intended to facilitate kind, humane, and compassionate service for these patients, while relieving pre-hospital care providers of the burden and responsibility for making medical moral, legal and ethical decisions in the field, regarding patient competency, authenticity of documents, and legality of requests and relationships. As with any order, the patient can revoke this decision for limited services at any time.

PROCEDURE FOR PATIENTS REQUESTING LIMITED SERVICES

A. Patients and their physicians who desire limited care services must:

1. Discuss the appropriate limitations of services, based on patient's desires and his or her medical condition;
2. Complete the attached request and return it to the Department and County Medical Control Board at least seven (7) business days prior to the desired implementation date of this service;
3. Make sure the request is filled out completely.

- B. The Project Medical Director or designee should review each case to insure that all necessary information is asked to authorize limited service for patients where appropriate.
- C. The Authorization will be distributed to:
 - 1. The Medical Control Board;
 - 2. The Medical Control Telecommunication Center;
 - 3. The patient's designated receiving hospital emergency department;
 - 4. The private/attending physician;
 - 5. The patient, or the patient's surrogate, with the identification wristband.
- D. The patient who has authorized limited services will be identified by a colored plastic band to be worn on either wrist. The plastic band will note the patient's name, a designated number, authorization and expiration dates and the name of the Medical Control Authority.
- E. Removal of the band signifies a change in the patient's status nullifying the previous limited service decision at any time. The patient can revoke the limited service decision at any time. The patient then reverts to full treatment status.
- F. Any suspicion of foul play nullifies the limited service status. The patient then reverts to full treatment status.
- G. The responding pre-hospital care provider will notify medical control and the receiving emergency department of the patient's limited service status as soon as possible.
- H. In the event that an identified limited care patient cannot be transported to the designated receiving hospital, the limited service information will be transmitted to the alternative receiving hospital emergency department by the medical control telecommunications center.
- I. All decisions regarding emergency care and treatment will ultimately be made by the emergency department physician providing medical direction to the pre-hospital care provider.
- J. No patient will be refused transportation to the hospital on the basis of limited service status.
- K. The limited services status expires six months from the date of approval. The limited service status may be continued and/or re instituted by re-application as outlined within this guideline and procedure.

MEDICAL CONTROL BOARD PATIENT REQUESTS FOR LIMITED SERVICE

Board Use Only

PATIENT NAME: _____ Date Requested: _____

ADDRESS: _____ Date Effective: _____

CITY: _____ PHONE: _____ Date Expired: _____

PRIVATE PHYSICIAN: _____
Initials PMD

DIAGNOSIS: _____

PREFERRED RECEIVING HOSPITAL: _____

ADVOCATE, NEXT OF KIN OR LEGAL GUARDIAN: _____ Phone: _____

LIMITATIONS TO CARE:

- _____ No Intubation
- _____ No Blood
- _____ No IV's
- _____ No Chest Compression (CPR)
- _____ No Respiratory Assistance (CPR)
- _____ No Oxygen
- _____ No Pacemaker
- _____ No Resuscitative Drugs
- _____ No Vasopressors
- _____ No Antibiotics
- _____ Other (Specify)

I, _____, certify that I am the private/attending physician for _____ . I certify that the patient and I have reached a joint decision that the above limitations are appropriate given the patient's condition and beliefs.

Physician's Signature

I, _____, request the specific limitations listed above.

Patient or Patient's Surrogate

GUIDELINE FOR RECOMMENDED WORDING OF PATIENT REFUSALS

RELEASE FROM RESPONSIBILITY WHEN PATIENT REFUSES SERVICES

This is to certify that I, _____, being fully competent and aware of my actions, am refusing the services offered by the emergency response personnel. I acknowledge that I have been informed of the risk and/or complications that may develop from my refusal of services. I have also been informed of the care the receiving facility will provide me, and the rationale supporting these treatments. I hereby release the emergency response personnel, the physician consultant, and the consulting hospital from any ill effects which may result from this action.

Witness (should not be EMS Provider)

Affiliation

Patient Name or Nearest
Relative

Witness (should not be EMS Provider)

Affiliation

Relationship