

APPENDIX: 31

TITLE: TREAT-AND-RELEASE CHECKLISTS

REVISED: November 1, 2018

## HYPOGLYCEMIA TREAT-AND-RELEASE CHECKLIST

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	1. Is there a clear reason for the hypoglycemic episode?
<input type="checkbox"/>	<input type="checkbox"/>	2. Is the patient alert and oriented?
<input type="checkbox"/>	<input type="checkbox"/>	3. Is the patient's repeat BG above 80 mg/dl
<input type="checkbox"/>	<input type="checkbox"/>	4. Has the patient's BG been well controlled prior to this episode?
<input type="checkbox"/>	<input type="checkbox"/>	5. Is the patient able to eat on complex carbohydrate meal?
<input type="checkbox"/>	<input type="checkbox"/>	6. Does the patient have a regular, on-going physician care?
<input type="checkbox"/>	<input type="checkbox"/>	7. Is the patient comfortable with non-transport by EMS?
<input type="checkbox"/>	<input type="checkbox"/>	8. Is the patient/guardian willing to sign a release form?
<input type="checkbox"/>	<input type="checkbox"/>	9. Is there another responsible person with the patient?
<input type="checkbox"/>	<input type="checkbox"/>	10. Is the patient's temperature within normal limits? Normal= 95° to 100.4° F
<input type="checkbox"/>	<input type="checkbox"/>	11. Is the patient free of the influence of alcohol or other CNS altering drugs?

Any "No" answer above requires contact with Medical Control prior to release.

Time: \_\_\_\_\_

Facility: \_\_\_\_\_

Physician: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

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Treat-and-Release Checklists

## EPISTAXIS TREAT-AND-RELEASE CHECKLIST

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	1. Has the epistaxis stopped?
<input type="checkbox"/>	<input type="checkbox"/>	2. Is the epistaxis <b>non</b> -traumatic in origin?
<input type="checkbox"/>	<input type="checkbox"/>	3. Is the patient alert and oriented?
<input type="checkbox"/>	<input type="checkbox"/>	4. Is the patient's systolic blood pressure below 180 mmHg?
<input type="checkbox"/>	<input type="checkbox"/>	5. Is the patient's diastolic blood pressure below 110 mmHg?
<input type="checkbox"/>	<input type="checkbox"/>	6. Is the airway stable and without compromise from bleeding?
<input type="checkbox"/>	<input type="checkbox"/>	7. Is the patient on blood thinners (excluding Aspirin)?
<input type="checkbox"/>	<input type="checkbox"/>	8. Does the patient have regular, on-going physician care?
<input type="checkbox"/>	<input type="checkbox"/>	9. Is the patient comfortable with non-transport by EMS?
<input type="checkbox"/>	<input type="checkbox"/>	10. Is the patient/guardian willing to sign a release form?
<input type="checkbox"/>	<input type="checkbox"/>	11. Is the patient free of the influence of alcohol or other CNS-altering drugs?

Any "No" answer above requires contact with Medical Control prior to release.

Time: \_\_\_\_\_

Facility: \_\_\_\_\_

Physician: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

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