

PATIENT REFUSAL OF TREATMENT/TRANSPORT

CALL IDENTIFICATION

Patient Name _____ Age _____

Call location _____ Date _____ Time _____ Unit# _____ Agency Run # _____

PATIENT ASSESSMENT Chief Complaint _____

VITAL SIGNS BP _____ Pulse _____ Resp _____

Oriented to: _____ Person _____ Place _____ Time _____ Situation _____

GENERAL ASSESSMENT

PATIENT INFORMED

- ____ Medical Treatment/ambulance transport needed
- ____ Further harm could result without medical evaluation/treatment
- ____ Transport by other than ambulance could be hazardous in light of patient's illness/injury

SPECIFIC EMS SERVICE REFUSED

- ____ Patient refused treatment
- ____ Patient refused ambulance transport
- ____ Patient refused ambulance transport to appropriate facility_

PATIENT DISPOSITION

- ___ Transported by private vehicle.
- ___ Released in care or custody of self.
- ___ Released in care or custody of relative or friend. _____
Name
- ___ Released in care or custody of other agency. _____

Agency Name _____ Name of Responsible Individual _____

PATIENT INSTRUCTIONS

___ Patient instructed to call 9-1-1 or follow up with his/her physician if condition persists or worsens.

The following statement should be read to the patient:

The evaluation and / or treatment provided to you by the EMS providers is not a substitute for medical evaluation and treatment by a doctor. By signing this, you indicate that you understand the nature of the proposed care and transportation and that you fully comprehend the potential consequences of this refusal. And that you further attest that you are capable and authorized to make said refusal, that you do forever release and give up any claim, demand, or action against all Emergency Medical Services personnel and their agents and do hereby covenant and agree to hold such persons harmless from any claim, demand, loss, or action for any alleged act or omission in the care or transport in compliance with this refusal. This release is binding on your heirs, executors, and assigns.

_____ Patient signature	_____ Print patient name	_____ Date	_____ Time
_____ Surrogate signature	_____ Print surrogate name	_____ Date	_____ Time
_____ Witness signature	_____ Print witness signature	_____ Date	_____ Time
_____ EMS personnel signature	_____ Print EMS Personnel Name	_____ Date	_____ Time