

Adirondack-Appalachian Regional Emergency Medical Services Council

REFUSAL OF MEDICAL CARE, TREATMENT, AND/OR TRANSPORTATION

PCR Number: _____ Date: _____ Time: _____

PATIENT: I understand that competent persons maintain the right to refuse medical care, treatment, and/or transportation. I, _____, hereby acknowledge that I have been advised by members of the _____ [Agency], that they recommend that I receive medical care, treatment, and/or transportation to a hospital emergency department for further evaluation by a physician.

I further understand that I may refuse medical care, treatment and/or transportation, but do so at my own risk. I do not have any known physical or mental condition that would prohibit me from making an informed, competent, and intelligent decision to refuse the medical care, treatment, and/or transportation that has been offered and recommended.

THE RISK ASSOCIATED WITH REFUSAL MAY INCLUDE POSSIBLE LOSS OF LIMB OR LIFE

I HAVE ALSO BEEN ADVISED THAT IF I DEVELOP ANY MEDICAL COMPLAINTS OR SYMPTOMS, I SHOULD IMMEDIATELY CONTACT AN AMBULANCE, HOSPITAL EMERGENCY DEPARTMENT, OR MY PHYSICIAN.

I, hereby, release _____ [Agency], its officers, agents, personnel, and employees from any and all claims, causes of action or injuries, of whatsoever kind or nature, arising out of or in connection with my refusal of medical care, treatment, and/or transportation.

Patient's Signature: _____ Date: _____

Patient's Name (print): _____ Patient's Age: _____ Patient Refused Signature: _____

FOR MINORS OR PERSONS WHO HAVE GUARDIANS: I am the patient's legal guardian. My relationship to the patient is _____. I am, hereby, acting on behalf of the patient, _____ [Patient's Name].

I have read the above information and refuse medical care, treatment, and/or transportation of behalf of the patient.

Guardian's Signature: _____ Date: _____

Guardian's Name (print): _____ Guardian's Full Address: _____

WITNESS: I, _____, witnessed members of the _____ [Agency] recommend to the patient medical care, treatment, and/or transportation to a hospital emergency department for further evaluation and attention. I further witnessed the above-named patient (or patient's guardian) decline such medical care, treatment, and/or transportation.

Witness' Signature: _____ Date: _____

Witness' Name (print): _____ Witness' Full Address: _____

Occupation: _____

EMS PROVIDER: I, _____ [EMS Provider], have offered and recommended to _____ [Patient's Name or Guardian's Name], emergency medical care and treatment, including transportation to a hospital. The patient (or patient's guardian) has refused my recommendation for medical care, treatment, and/or transportation. I have fully explained the reasons for medical care, treatment, and/or transportation to the patient (or patient's guardian). I have also explained this form to the patient (or patient's guardian) and have requested that he/she personally read it. The patient (or patient's guardian) has expressed to me an understanding of the information contained herein and did not have any questions regarding the content of this form. The patient (or patient's guardian) did not appear to me to be suffering from any illness or injury nor any condition that would affect his/her ability to refuse medical care, treatment, and/or transportation. The patient (or patient's guardian) is alert and oriented to person, place, time and situation.

EMS Provider Signature: _____ Date: _____

Provider Certification Level/NYS ID Number: _____ Police Agency Present: NO _____ YES _____

Police Officer's Name: _____ Police Agency Name: _____