

EMS Region Refusal of Treatment/Transport Form

Ver 2.1 rev 6/2010

Instructions to Provider: Complete this form for all patients who are assessed and refuse care and/or transport.
Complete all fields, enter N/A if Not Applicable and Attach to paper PCR or scan for electronic attachment to ePCR.

Name _____ Date of Service ____/____/____ Associated PCR _____

Determination of Mental Capacity

Does the patient meet of the following?

- Altered Mental Status? Yes No
Evidence of threat to self or others? Yes No
Unable to verbalize an understanding of the illness/injury and/or risks of refusing care? Yes No
Unable to verbalize rational reasons for refusing care despite the risks. Yes No
No legal guardian available to determine transport decision. Yes No

The patient must be legally able to refuse care (generally 18 years of age or older)

If any of the above responses are "yes" then the patient cannot refuse treatment/transport.

Medical Control Criteria

Check to indicate Medical Control was contacted

Absolute On-Line

- Medical Control must be contacted for a case of Apparent Life Threatening Event (ALTE) when the legal guardian is refusing transport.

At-Risk Criteria

Patients exhibiting the following at-risk criteria should have medical control consultation prior to refusal:

- Age greater than 65 or < 2 months.
- Pulse > 120 or <50.
- Systolic blood pressure >200 or <90.
- Respirations >29 or <10.
- Serious chief complaint (chest pain, SOB, syncope).
- Significant mechanism of injury or high suspicion of injury.
- Fever in a newborn less than 8 weeks old.

Provider Refusal Checklist

By signing, I confirm I have done the following:

- Determined the patient exhibits decisional capacity to refuse care/transport.
- Offered transport to a hospital.
- Explained the risks of refusing care/transport.
- Explained that by refusing care/transport, the possibility of serious illness of death may increase.
- Advised the patient to seek medical attention and gave instructions for follow-up care.
- Confirmed that the patient understands these directions.
- Ensured that the patient signed the Refusal of Treatment/Transport Form or documented why it was not signed.
- Left the patient in the care of a responsible adult when possible.
- Advised the patient to call 911 with any return of symptoms or if they wish to be re-evaluated and transported to the hospital

Provider Name _____

Provider Signature _____

NYS EMT# _____

Refusal of treatment: (Check all that apply)

Patient Assessment

Immobilization – C-Collar KED Longboard

IV Therapy Oxygen Therapy

Medications: _____

Other: _____

Refusal of treatment/transport Negativa a recibir tratamiento/ser trasladado

Release

Exoneracion de responsabilidades

I hereby refuse treatment and/or transport to a hospital and I acknowledge that such treatment or transportation was advised by the emergency crew or physician. I hereby release such persons from liability for respecting and following my express wishes.

Mediante la presente declare que me niego a aceptar el tratamiento/traslado a un hospital y reconozco asimismo que el medico o el personal de la emergencia recomendaron ese tratamiento/traslado. Consiguientemente, eximo a dichas personas de toda responsabilidad por haber respetado y cumplido mis deseos expresos.

Name (Nombre) _____

Date (Fecha) _____

Signed (Firma) _____

Time (Hora) _____

Witness (Testigo) _____