Your Ambulance Service
INFORMED DECISION OF REFUSAL OF CARE

Patient Assessment

Patient Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____ SS#: _____

(A) Legal Capacity
Note: If answer to at least one of the questions in this section is "YES," the patient may sign this form in most states. If "NO" to all, signature of legally authorized decision maker required.

Is patient over 18? Yes ___ No ___ If patient is a minor, is patient married? Yes ___ No ___
If patient is a minor, is patient pregnant? Yes ___ No ___ Comments/Quotes/Observations: _____

(B) Mental Capacity
Note: If "YES" to any question in (B), Patient *may* lack capacity to refuse care, though this is a fact-specific determination and consultation with medical control is encouraged. Do not release Patient or allow to sign form unless explanation noted or, if Patient is less than 18 years of age, the form is signed by a parent or legal guardian.

Disoriented to: Person? Yes ___ No ___ Possible ETOH / drug use? Yes ___ No ___ Odor of ETOH? Yes ___ No ___
Place? Yes ___ No ___ Admitted by Patient? Yes ___ No ___ Unsteady Gait? Yes ___ No ___
Time? Yes ___ No ___ Slurred speech? Yes ___ No ___

Comments/Quotes/Observations: _____

(C) Medical Capacity
Note: If "YES" to any questions in (C) Patient *may* lack capacity to refuse care, though this is a fact specific determination and consultation with medical control is encouraged. Do not release Patient or allow to sign form unless explanation noted or, If Patient is less than 18 years of age, the form is signed by a parent or legal guardian.

Head Injury? Yes ___ No ___ Altered LOC? Yes ___ No ___ Abnormal Glucose? Yes ___ No ___ Reading _____
Abnormal Pupils? Yes ___ No ___ Severe SOB? Yes ___ No ___ Abnormal SAO2? Yes ___ No ___ Reading _____

Comments/Quotes/Observations: _____

(D) Medical Control Physician Name: _____ Contacted by? Phone ___ Radio ___ On Scene ____
Orders: Release Patient _____ Use Reasonable Force / Restraint to Treat _____ Transport ____

Comments/Quotes/Observations: _____

_____

Was the Patient notified of current medical condition? Yes ___ No ___

Was the Patient notified of the risks of refusing care? Yes ___ No ___

Did the Patient understand the risks of refusing care and transport? Yes ___ No ___

Was the Patient offered transport? Yes ___ No ___

Who initiated the refusal? Patient ___ or Crew ___

Comments: _____

(F) Provider Signature: Attendant: _____ Witness: _____

Patient Advice

Patient Name: _____ Date: _____

This form is being provided to me because I have:

☐ Refused Assessment ☐Refused Treatment ☐Refused Transport

I understand that the EMS personnel are not physicians and are not qualified or authorized to make diagnosis and that their care is not a substitute for that of a physician. I recognize that I may have a serious injury or illness which could get worse without medical attention even though I (or the patient on whose behalf I legally sign this document) may feel fine at the present time.

I recognize that by refusing care and transport I may suffer further illness or injury and even death. _____

I understand that I may change my mind and call 9-1-1 if treatment or assistance is needed later. I also understand that treatment is available at an emergency department 24 hours a day or from my physician.

I acknowledge that this advice has been explained to me by the ambulance crew and that I have read this form completely and understand its provisions. I agree, on my own behalf (and on the behalf of the patient for whom I legally sign this document), to release, indemnify and hold harmless Your Ambulance Service and its officers, members, employees or other agents, and the medical control physician and medical control facility, from any and all claims, actions, causes of action, damages, or legal liabilities of any kind arising out of my decision, or from any act or omission of Your Ambulance Service or its crew, or the medical control physician or medical control facility.

I also acknowledge receipt of Your Ambulance Service Notice of Privacy Practices.

Other specific instructions to Patient: _____

_____

Signature: _____ Date: _____

☐ Patient ☐ Parent ☐ Legal Guardian

Witness: _____

☐ Family ☐ Fire ☐ Driver ☐ Other

If the Patient refuses to sign:

I attest that the patient has refused care and / or transportation by Your Ambulance Service The patient was informed of the risks of this refusal and refused to sign this form when asked by Your Ambulance Service

Witness: _____ Print Name: _____