

Monroe-Livingston EMS Region Refusal of Treatment/Transport Form

Ver 1.4 Rev 10/2007

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. Attach to paper PCR or scan for electronic attachment to ePCR.

Agency Name _____ **Date of Service** _____ **Associated PCR** _____

Medical Decision Making Capacity Determination

Is the patient disoriented to:

Person? Yes No
 Place? Yes No
 Time? Yes No
 Situation? Yes No

Altered level of consciousness? Yes No
 Suspected head injury? Yes No
 Intoxication from alcohol or drugs? Yes No
 Age under 18 and not emancipated? Yes No
 Evidence of threat to self or others? Yes No
 Involuntary commitment pursuant to NYS Mental Hygiene Law? Yes No

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

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 or 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# _____

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 > 65 years 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.

Reason for refusal of care and/or transport and directions for follow-up care:

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) _____ Patient refused to sign