REFUSAL OF TREATMENT, TRANSPORT AND/OR EVALUATION

Patient's Printed Name			
Patient's Address			
City	State	Zip Code	
Phone	DOB	Age	
Patient left in care or custody of: ☐ Self ☐ Friend/Relative ☐ Law ☐ Healthcare ☐ Other			

Incident/Run #	Date
Incident Location	

Patient Cognitive Assessment		
1. Oriented to person, place, and time?	☐ Yes	☐ No
2. Coherent speech?	☐ Yes	☐ No
3. Auditory and/or visual hallucinations?	☐ Yes	☐ No
4. Suicidal or homicidal?	☐ Yes	☐ No
5. Able to repeat understanding of their condition and consequences of refusal?	☐ Yes	☐ No

Time	BP	Pulse	Resp.	Skin	Pupils	LOC

Narrative - Describe reasonable alternatives to treatment that were offered; the circumstances of the call; specific consequences of refusal; and, names of family or witnesses present (also shall be included in Patient Care Record):

PATIENT - PLEASE READ COMPLETELY BEFORE SIGNING BELOW!

Because it is sometimes impossible to recognize actual or potential medical problems outside the hospital, we strongly encourage you to be evaluated, treated if necessary, and transported to a hospital by EMS personnel for more complete examination by a physician.

You have the right to choose to not be evaluated, treated or transported if you wish; however, there is the possibility that you could suffer serious complications or even death from conditions that are not apparent at this time.

By signing below, you are acknowledging that EMS personnel have advised you and that you understand the potential harm to your health that may result from your refusal of the recommended care; and, you release EMS and supporting personnel from liability resulting from refusal. **If you change your mind or your condition becomes worse and you decide to accept treatment/transport by EMS, please do not hesitate to call 911 immediately. Signing this refusal should not prevent you from calling 911 again or from seeking medical treatment on your own through other means.**

PLEASE CIRCLE THE FOLLOWING THAT APPLY:

I refuse the following: EVALUATION TREATMENT TRANSPORT

Signature of Patient/Representative	Relationship, if applicable			Date
Witness Signature	Printed Name of Witness			Date
Signature of Provider	Printed Name of Provider	Agency	Unit	Date

SAGINAW VALLEY MEDICAL CONTROL AUTHORITY