Glatfelter Commercial Ambulance℠
A Division of Glatfelter Insurance Group

EMS Patient Refusal Check List

Patient Name: _____ Age: ____ Date: _____
Incident Location: _____ Report #: _____
Situation of Injury/Illness or Chief Complaint: _____

I. Assessment of Patient (*Consider consulting Medical Command)

1. Oriented to: Person ☐ Yes ☐ No* Place ☐ Yes ☐ No* Time ☐ Yes ☐ No* Event ☐ Yes ☐ No*
2. Altered level of consciousness? ☐ Yes* ☐ No
3. Head Injury ☐ Yes* ☐ No
3. Alcohol or drug ingestion ☐ Yes* ☐ No
5. Suicide attempt ☐ Yes* ☐ No
6. Chest Pain, Dyspnea or Syncope ☐ Yes* ☐ No

II. Medical Control

☐ Physician Name: _____ Phone: _____ Radio at _____ hours.
☐ Unable to contact (explain in comments) _____
Orders:

- ☐ Indicated treatment and/or transport may be refused by patient.
- ☐ Use reasonable force and/or restraints to provide indicated treatment.
- ☐ Use reasonable force and/or restraint to transport.
- Other: _____

III. Patient Advised (Complete each item, check appropriate response)

- ☐ Yes ☐ No Medical treatment /evaluation and/or transport is recommended
- ☐ Yes ☐ No EMS evaluation/treatment is not a substitute for physician evaluation/treatment.
- ☐ Yes ☐ No Further harm could result without medical treatment/evaluation.
- ☐ Yes ☐ No Transport by means other than ambulance could be hazardous in light of patient's present illness/injury.
- ☐ Yes ☐ No Patient provided with refusal Information sheet.
- ☐ Yes ☐ No Patient would not accept refusal information sheet.

IV. Disposition

- ☐ Refused all EMS services.
- ☐ Refused transport, accepted field treatment.
- ☐ Refused field treatment, accepted transport.
- ☐ Released in care of custody of self.
- ☐ Released in custody of law enforcement agency:
  Agency: _____ Officer: _____
- ☐ Released in care of custody: ☐ of relative ☐ of friend
  Name: _____ Relationship: _____

V. Comments: (use back of page, if additional space is needed) _____

_____

Signature of Provider _____ Date _____
Signature of Witness _____ Date _____

Glatfelter Commercial Ambulance℠
A Division of Glatfelter Insurance Group

Patient Refusal Information Sheet

Please Read and Keep This Form!

This form has been given to you because you have refused treatment and/or transport by the Emergency Medical Service. Your health and safety are our primary concern. Even though you have decided not to accept our advice, please remember the following:

Initials _____ 1. The evaluation and/or treatment provided to you by the rescue squad is not a substitute for medical evaluation and treatment by a doctor. We advise you to get medical evaluation and treatment.

Initials _____ 2. Your condition may not seem as bad to you as it actually is. Without treatment, your condition or problem could become worse. If you are planning to get medical treatment, a decision to refuse treatment or transport by the EMS may result in a delay which could make your condition or problem worse.

Initials _____ 3. Medical evaluation and/or treatment may be obtained by calling your doctor, if you have one, or by going to any hospital Emergency Department in this area, all of which are staffed 24-hours a day by Emergency Physicians. You may be seen at these Emergency Departments without an appointment.

Initials _____ 4. If you change your mind or your condition becomes worse and you decide to accept treatment and transport by the Emergency Medical Service, please do not hesitate to call us back, by dialing 911. We will do our best to help you.

Initials _____ 5. Don't wait! When medical treatment is needed, it's usually better to get it right away.

☐ 6. If the box at the left has been checked, it means that your problem or condition has been discussed with a doctor at the hospital by radio or telephone and the advice given to you by the Emergency Medical Service has been issued or approved by the doctor.

☐ 7. If the box at the left has been checked that indicates that you are the patients legal guardian in this situation and are acting on behalf of the patient. By signing below you indicate that you have read and understand the above information regarding refusal of treatment/transport.

Guardian's Name (Printed): _____Relationship to Patient: _____
Guardian's Signature: _____ Date: _____

I have received a copy of this Refusal Information Sheet

Patient's Signature: _____ Date: _____
Patient's Name Printed: _____ Date: _____
Provider's Signature: _____ Date: _____
Witness Signature: _____ Relationship to Patient: _____