

Date _____ Agency incident # _____

Patient name _____ Home address _____ City _____ State _____ Zip _____ Phone # _____ DOB _____ Age _____ Sex _____	Agency _____ Unit ID _____ Location of call _____ _____ City _____	Call Times (24-hour) Call received _____ Dispatched _____ En route _____ Arrive on scene _____ # minutes—enr. to scene _____ Depart scene _____ # minutes—time on scene _____
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 Dispatched for _____

 Patient complaint _____

 Recent medical events or changes _____

 Did the patient request EMS?
 Y N

 Did the patient agree to
 assessment and vital signs?
 Y N

 Was the patient conscious
 and alert with decision-
 making capability when
 refusal was signed? Y N

*(If no, contact Medical Control and
 include in narrative.)*

Time	B/P	HR	RR	SPO2	B.G.	EKG	Lung sounds	Pupils	Skin

 Narrative _____

Crew #1 _____	#	_____
Crew #2 _____	#	_____

Option 1 ACKNOWLEDGMENT AND RELEASE OF LIABILITY FOR ALL HEALTHCARE PROVIDERS

I, _____, hereby acknowledge and release the above-mentioned emergency service provider and its personnel, Springfield Memorial Hospital, and all EMS system physicians, nurses, agents and personnel of any liability for my refusal to accept further treatment. I acknowledge that I have been advised of and understand the risks of not accepting emergency treatment and/or transportation to the nearest hospital facility, which I am refusing.

- I have been advised as follows:
- That I should receive emergency medical treatment and transportation to a hospital, which I am refusing.
 - That having received emergency medical treatment, I am refusing further aid or transport to a medical facility.
 - I am refusing all medical assessment, treatment and transport.
 - That my failure to seek treatment and transport could result in permanent injury, impairment, disability and could lead to my death.
 - I certify that I have the ability and appreciate the consequences of making decisions regarding my medical treatment and the ability to reach an informed decision.
 - I have been made aware and understand that I can call 9–1–1 again and at any time.

Signature of patient or authorized representative _____ Date _____ Time _____

Option 2 REFUSAL TO SIGN RELEASE STATEMENT

The above patient was informed and read the above release from medical responsibility clause and was asked to sign due to his/her refusal of Emergency Medical Services. The above patient was informed of the risks of not receiving emergency medical assessment, treatment and/or transportation to the nearest medical facility, and still stated his/her refusal to sign the above. The above-described patient has the ability to understand and appreciate the consequences of making decisions regarding medical treatment and the ability to reach an informed decision and sufficient understanding to make responsible decisions concerning the medical care of his/her person.

 Signature of witness #1 _____ Date/time _____ Printed _____ Phone _____
 Signature of witness #2 _____ Date/time _____ Printed _____ Phone _____