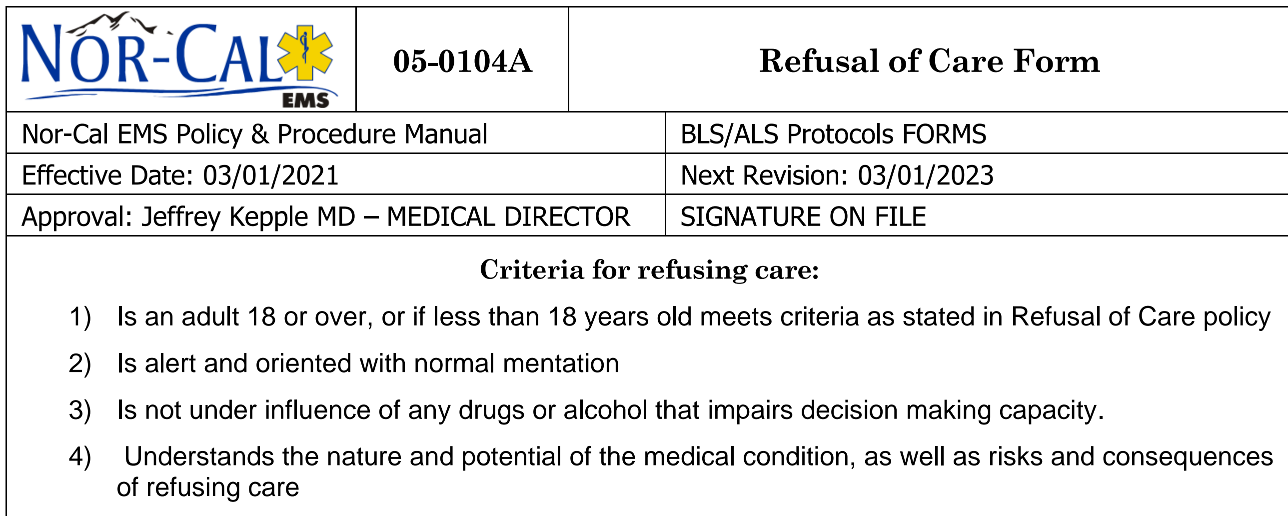

NOR-CAL EMS	05-0104A	Refusal of Care Form
Nor-Cal EMS Policy & Procedure Manual		BLS/ALS Protocols FORMS
Effective Date: 03/01/2021		Next Revision: 03/01/2023
Approval: Jeffrey Kepple MD – MEDICAL DIRECTOR		SIGNATURE ON FILE

Criteria for refusing care:

1) Is an adult 18 or over, or if less than 18 years old meets criteria as stated in Refusal of Care policy
2) Is alert and oriented with normal mentation
3) Is not under influence of any drugs or alcohol that impairs decision making capacity.
4) Understands the nature and potential of the medical condition, as well as risks and consequences of refusing care

Patient Name:_____________________________ DOB__________________

The following applies to me or the patient I am representing:

- ☐ I am refusing medical assessment and/or treatment.
- ☐ I am refusing medical transport to an emergency department.
- ☐ I am insisting on transport to a hospital other than transport by EMS personnel.

ACKNOWLEGDMENT OF INFORMATION:

I have been advised that medical assistance on my behalf, or on the behalf of the patient I am representing, is necessary, and that refusal of said assistance could be hazardous to my health, and under certain circumstances could include disability and/or death. I have been advised to discuss my medical complaints with my regular health care provider as soon as possible. Nevertheless, I refuse to accept treatment or transport to a medical facility and assume all risks and consequences of my decision.

I may change my mind and call 911 or seek medical assistance from an emergency department 24 hours a day.

RELEASE OF LIABILITY:

By signing this form, I am releasing the responding EMS personnel, Provider Agency(ies), and the base hospital of any liability or medical claims resulting from my decision to refuse the medical care/transport offered, or from any act or omission of the EMS providers, their personnel, or the base hospital.

Patient / Representative signature:___________________________ Date_______________

Witness signature:___________________________ Date_______________

EMS Provider signature:_______________________