EMERGENCY MEDICAL SERVICE (EMS) LIABILITY RELEASE
SANDOVAL COUNTY FIRE DEPARTMENT

DATE:_____TIME:_____LOCATION:_____

Refusal Criteria: Age:_____ □ Alert/ Oriented □ Clear Judgement

(The above three criteria should be completed for all patients and non-patients.)

□ No Suicidal Tendencies □ No Psychotic Behavior □ Vital Signs Within Normal Limits

□ Appropriate Neurological Exam □ Understands Risks Associated with Refusal of Care

ALL BOXES MUST BE CHECKED WHEN OBTAINING A PATIENT REFUSAL. ANY EXCEPTION TO THE ABOVE MUST BE DOCUMENTED IN DETAIL IN THE BODY OF THE CHART NARRATIVE.

Refusal of EMS Care and Transport Against Medical Advice:

I have been assessed and / or treated for illness or injuries by EMS. I have been advised I have at least one potentially serious illness or injury, which needs further treatment. I understand that failure to treat this illness or injury may lead to my disability or death. I REFUSE further treatment by EMS, as well as transport by EMS to the hospital of my choice, in accordance with EMS protocols and/or medical direction. I also understand that signing this refusal does not preclude me from later obtaining medical care on my own and/or requesting another EMS response.

My initials here indicate that this section applies to me:_____

Assessment and/ or Treatment without EMS Transport:

I have been assessed and/or treated for illness or injury by EMS. I have been advised and understand I may need further assessment and treatment by a physician. I have also been advised of possible signs and symptoms that my condition may be changing. I REFUSE further treatment and transport by EMS to the hospital of my choice in accordance with EMS protocols and/or medical direction. I also understand that signing this refusal does not preclude me from later obtaining medical care on my own and/or requesting another EMS response.

My initials here indicate that this section applies to me:_____

Juvenile/ Incompetent Patient:

_____has been assessed and/or treated for illness or injuries by EMS. As his/her parent/ guardian/P.OA. (Circle one), I have been advised and understand that he/she may need further assessment and treatment by a physician. I REFUSE further treatment of him/her by EMS as well as transport by EMS of him/her to the hospital of my choice, in accordance with EMS protocols and /or medical direction. I also understand that signing this refusal does not preclude me from later obtaining medical care for him/her and /or requesting another EMS Response.

My initials here indicate that this section applies to me:_____

Non-Patient

EMS has met with me, and I have told him/her that I have no medical complaint, illness or injury. I do not consider myself to be a patient. I Have been advised and understand that I may need further assessment and treatment by a physician. I REFUSE treatment as well as transport by EMS to the hospital consistent with EMS protocols and/or medical direction. I also understand that signing this refusal does not preclude me from later obtaining medical care on my own and/or requesting another EMS response.

My initials here indicate that this section applies to me:_____

Acceptance of Responsibility and Release of EMS (REQUIRED FOR ALL SECTIONS):

I understand that EMS has made a good faith determination that I am alert, oriented and able to make decisions for my ward or myself. I have read, or have had read to me, the section I have initialed above. My EMS assessment and my treatment options were explained to me and I understand them. I have no further questions of EMS at this time. I now knowingly and voluntarily release all individuals, organizations and entities participating in and under the Sandoval County EMS system Protocols and Guidelines from any liability for any and all claims arising from my decisions regarding my or my ward's healthcare. **□ EMS has explained and I have received the PHI Document.**

Name_____DOB_____ Telephone _____

Address _____ City _____ State _____ Zip _____

Translator/ Parent/ Guardian Name _____ Signature _____

Witness 1 _____Witness 2_____

Provider Name _____ Provider Signature_____

MCEP (If Applicable)_____ **Run #_____**