SOLANO COUNTY EMS

REFUSAL OF MEDICAL ASSISTANCE FORM

EMS Service:	Date:	Time:
Patient Name:	Age:	Phone #
Incident Location:		Incident #
Situation of EMS Call:		NON PATIENT: ☐ (see Non-Patient Encounter Form)

PATIENT ASSESSMENT:

Any current medical complaint: ☐ Yes ☐ No (If yes – describe: _____)

Suspected injury or illness based on patient history, physical examination or mechanism of injury: ☐ Yes ☐ No

**** Check marks in shaded areas should prompt law enforcement assessment for protective custody or 5150 Hold before patient release. ****

Competency to Refuse Medical Assistance:

18 years of age or older: ☐ Yes ☐ No		Any evidence of:	Suicidal? ☐ Yes ☐ No
			Head Injury? ☐ Yes ☐ No
Patient Oriented to:	Person: ☐ Yes ☐ No		Intoxication? ☐ Yes ☐ No
	Place: ☐ Yes ☐ No		Any altered mental status? ☐ Yes ☐ No
	Time: ☐ Yes ☐ No		Mentally impaired in any way? ☐ Yes ☐ No
	Event: ☐ Yes ☐ No		

Risks explained to patient: _____

Patient understands clinical situation and risks ☐ Yes ☐ No

Patient verbalizes understanding of risks: ☐ Yes ☐ No

Patient's plan to seek further medical evaluation: _____

Who will be with the patient after EMS departure? _____

LAW ENFORCEMENT ASSESSMENT FOR 5150 (if applicable):

AGENCY: _____ Officer: _____Badge # _____

BASE STATION CONTACT:

Physician: _____ BASE STATION: _____ TIME: _____

Base Physician spoke to patient: ☐ Yes ☐ No

Base Physician Orders: _____

PATIENT OUTCOME:

_____ Patient refuses transportation to a hospital against medical advice;

_____ Patient accepts transportation to hospital by EMS but refuses any or all treatment offered.

Treatment refused: _____

_____ Other: (Explain): _____

This form is being provided to me because I have refused assessment, treatment and/or transportation by EMS personnel for myself or on behalf of this patient. I understand that EMS personnel are not physicians and are not qualified or authorized to make a diagnosis and that their care is not a substitute for that of a physician. I recognize that there may be a serious injury or illness which could get worse without medical attention even though I (or the patient) may feel fine at the present time. I understand that I may change my mind and call 911 if treatment or assistance is needed later. I also understand that treatment is available at an emergency department 24 hours a day. I acknowledge that this advice has been explained to me by the EMS Personnel and that I have read this form completely and understand its terms.

_____	_____	_____
Signature (patient or other)	Date	EMS Provider Signature

If other than patient, print name and relationship to patient

PROVIDER COPY

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PATIENT COPY

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_____ _____ _____

Signature (patient or other) Date EMS Provider Signature

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EMS COPY

NON-PATIENT ENCOUNTER FORM

ENCOUNTER CHECKLIST:

Yes	No	
☐	☐	Has a physical complaint: The individual has a complaint of recent or new onset such as pain, shortness of breath, or weakness
☐	☐	Has obvious injury: The individual has signs of injury such as cuts or abrasions following a traumatic event
☐	☐	If the individual specifically called for or requests medical evaluation and/or care
☐	☐	Has been involved in an incident, or has experienced a mechanism, with potential for serious injury such as: a. A motor vehicle crash with intrusion into passenger space, broken windshield, bent steering wheel, or damaged dashboard b. Ejection from a vehicle c. Rollover incident involving unrestrained persons d. A motorcycle or other wheeled vehicle crash with damage to helmet, speed greater than 20 mph or separation of the rider from the vehicle e. A pedestrian (or rider of a wheeled vehicle) struck by a vehicle traveling at any speed
☐	☐	Has an altered mental status (recent or current)
☐	☐	A person who is unconscious or has a history of fainting or seizure
☐	☐	A person who is not fully oriented to person, place or time
☐	☐	Is possibly under the influence of drugs or alcohol or exhibits any impairment in sensorium.

- If a "**YES**" is marked, a PCR **must** be completed.
- If ALL are marked "**NO**", then complete TOP section of Provider Copy **only**.

NOTE: The above checklist must be completed on all potential Non-Patient encounters. If any of the above items is marked "**YES**", this person is a "**PATIENT**".

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