



Refusal of EMS Care Form (850-A)



EMS Agency:	Incident #:
Patient Name:	Patient DOB:
Base Hospital: <input type="checkbox"/> N/A	MICN/Physician: <input type="checkbox"/> N/A

The following apply to me or the patient I am representing (check all that apply):

- I am refusing medical assessment.
- I am refusing medical treatment.
- I am refusing medical transportation.
- I have received medical assessment and treatment, but decline medical transportation.
- I am insisting on medical transport to a hospital other than EMS personnel recommend.

I understand that EMS personnel are not physicians, are not qualified or authorized to make a medical diagnosis, and that their care is not a substitute for that of a physician. I recognize that I, or the patient I am representing, may have a serious injury or illness which could get worse without medical attention even though I, or the patient I am representing, may feel fine at the present time.

I understand that I may change my mind and call 911 if medical assistance, treatment, or transportation is needed at a later time. I also understand that medical treatment is available at an emergency department 24 hours a day or from my/the patient's physician. If I have insisted on being transported to a destination other than that recommended by EMS personnel, I understand that I have been informed that there may be a significant delay in receiving care at the emergency department, that the emergency department may lack the staff, equipment, beds or resources to care for me promptly and/or that I might not be able to be admitted to that hospital.

I acknowledge that this advice has been explained to me by EMS personnel and that I have read this form completely and understand its provisions. I agree on my own behalf, or on behalf of the patient I am representing, to release, indemnify and hold harmless all EMS providers and their officers, members, employees or other agents, and the base hospital, from any and all claims, actions, causes of action, damages, or legal liabilities of any kind arising out of my decision, or from any act or omission of the EMS providers or their personnel, or the base hospital or their personnel.

Patient Instructions:

Patient Signature: Patient Representative – Relation to Patient: _____

Name **Signature** **Date**

Witness Signature: Immediate Family Member Law Enforcement Officer EMS Provider

Name **Signature** **Date**

Patient/Patient Representative Refusal to Sign: I attest that the patient/patient representative has refused EMS assessment, treatment and/or transportation. The patient/patient representative was informed of the risks of refusal and refused to sign this form when asked by EMS personnel.

Witness Signature: Immediate Family Member Law Enforcement Officer EMS Provider

Name **Signature** **Date**