McLean County Area EMS System

Release of Medical Responsibility Form

Run #	Assistance		Communications	Type of Service
Date	Police	Fire	MERCI _____	ALS__ ILS__ BLS__ FR__
Times		Vehicle	Cellular/ _____ Telemetry Hospital _____	Nature of Call
Call Received / Dispatched / Enroute / On Scene		Dispatch	I D # _____	
Location Responded To			Crew	
Patient Information				
Last Name	First	Initial	Age	DOB
Address			City	State
Zip	Phone			

I, _____ hereby release the hospitals of the McLean County Area EMS System, Physicians, Nurses, and any EMS Personnel of any responsibility. I acknowledge:

- ☐ That I should have emergency first aid, or other medical treatment, which I am refusing.
- ☐ That I have received emergency medical treatment, I am refusing further aid or transport to a medical facility.
- ☐ I am refusing any medical exam, treatment, or transport.
- ☐ I did not initiate a call for emergency service. I do not need medical attention or have any medical complaint or illness requiring treatment and/or transport to a medical facility. As a result, I am refusing any and all services offered.
- ☐ I am insisting on being transported to a hospital other than that which the EMS personnel recommended, regardless of possible risks associated with a longer travel time.

I understand that the 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 I may have a serious injury or illness which could get worse without medical attention even though I (or the patient on whose behalf I legally sign this document) may feel fine at the present time.

I understand that I may change my mind and call 9-1-1 if treatment or assistance is needed later. I also understand that treatment is available at an emergency department 24 hours a day or from my physician. If I have insisted on being transported to a destination other than that recommended by the EMS personnel, I understand and have been informed that there may be a significant delay in receiving care at the emergency room, that the emergency room 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 the ambulance crew and that I have read this form completely and understand its provisions. I agree, on my own behalf (and on behalf of the patient for whom I legally sign this document), to release, indemnify and hold harmless the ambulance service and its officers, members, employees or other agents, and the Medical Control Physician and Medical Control facility 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 ambulance service or its' crew, or the Medical Control Physician or Medical Control facility.

_____ Signature of Patient/Person Authorizing Refusal

_____ Witness

_____ Address

Refusal to Sign Release Statement

Name of Patient/Person:_____

Address of Above:_____

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 service he/she had requested.

Crew Signatures:

1._____ 3._____

2._____ 4._____

Original- Service Privider Yellow Copy- EMS Office Pink Copy- Patient

DP: MCEMS Release/Checklist.indd r/04/17/08

McLean County Area EMS System

Patient Assessment Checklist for Refusals

Patient Name_____ Age_____ Date_____

A. Legal Capacity

Note: If answer to at least one question is "Yes", the patient may sign the form. If the answer is "No" to all, signature of a legally authorized decision maker is required.			Comments, Quotes, Observations:
	Yes	**No**	
Is patient over 18?			
If a minor, is patient married?			
If a minor, is patient pregnant?			

High Risk Patients
1. Head Injury
2. Any Trauma with significant mechanism
3. Chest Pain
4. SOB/dyspnea
5. Syncope
6. Seizure (new onset)
7. Headache (new onset)
8. TIA/resolving stroke symptoms
9. Pediatric complaints
10. Presence of alcohol and/or drugs
11. Altered level of consciousness or impaired judgment

B. Mental Capacity

Note: If answer is "Yes" to any question in "B", patient *may* lack the capacity to refuse care. Though this is a fact-specific determination, consultation with Medical Control is required. If the answer is "No" to all, the patient may sign the form. If patient is less than 18 years of age, the form must be signed by a Parent or legal guardian.			Comments, Quotes, Observations:
	Yes	**No**	
Disoriented to person?			
Disoriented to place?			
Disoriented to time?			
Possible ETOH/Drug use?			
Admitted by patient?			
Slurred speech?			
Unsteady gait?			

C. Medical Capacity

Note: If answer is "Yes" to any question in "B", patient *may* lack the capacity to refuse care. Though this is a fact-specific determination, consultation with Medical Control is required. If the answer is "No" to all, the patient may sign the form. If patient is less than 18 years of age, the form must be signed by a Parent or legal guardian.				Comments, Quotes, Observations:
	Yes	**No**		
Head Injury?				
Abnormal pupils?				
Altered LOC?				
Severe SOB?				
Abnormal glucose?			mg/dl	
Abnormal SaO2?			%	

Low Risk Patients
1. Slow Speed MVC without Injury
2. Isolated injuries not associated with significant mechanism
3. False calls or other "third party" calls where no illness, injury or mechanism of injury is apparent
4. Lifting assistance or "public assist" calls

D. Medical Control

Hospital Contacted_____	Comments, Quotes, Observations:
Physician Name_____	
Contacted by: Radio___ Phone____	
Orders: Release patient _____ Use reasonable force/restraint to treat _____ Transport _____	

E. Destination/Divert

Diverted by:_____ Diverted to:_____

Reason:_____

F. Crew Signatures

1._____ 2._____

3._____ 4._____

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❒ MEDICAL EMERGENCIES

Please watch for any or all of the following signs or symptoms.

Fever or Chills
Paralysis
Diarrhea/Vomitting
Wheezing
Blood in Stools
Headache
Burning Urination
Frothy/bloody Sputum
Numbness/tingling
Abdominal Tenderness
Blood in Urine
Chest Pain
Dizziness
Frequent Urination
Bluish Skin Color
Loss of Specific Function
Abdominal Pain
Shortness of Breath
Chest Discomfort
Weakness

❒ TRAUMA EMERGENCIES

Please watch for any or all of the following signs or symptoms.

Dizziness
Unsteady gait
Difficulty Walking
Swelling
Pain
Nausea/Vomitting
Headache
Numbness/tingling
Change of Mental Status
Redness and/or Warmth
Abdominal Distension
Inability/difficulty with moving extremity
Visual Difficulty
Lack of Coordination
Difficulty Speaking
Loss of Consciousness
Tenderness

❒ POSSIBLE DRUG OVERDOSE AND/OR POISONING

Please watch for any or all of the following signs or symptoms.

Nausea/vomitting
Tremors
Blurred Vision
Headache/dizziness
Fever/Chills/Sweating
Loss of Consciousness
Change in Mental Status
Rash/hives
Shortness of Breath

YOU HAVE REFUSED AID, TREATMENT OR TRANSPORTATION against the advice of the Emergency Medical Service Provider present at the scene. The above signs and symptoms are being listed as the most common signals of a problem or developing problem.

If you are presently experiencing or if you encounter any of the above signs and/or symptoms, we advise that you immediately seek medical attention. You understand that your refusal for treatment and transportation to an appropriate Hospital may be detrimental to your health or may even lead to death. If you encounter other signs and/or symptoms not listed above, we advise you to also seek immediate medical attention.

IF YOU WISH TO RECONSIDER YOUR REFUSAL OF EMERGENCY TREATMENT AND/OR TRANSPORT, PLEASE RECONTACT THE RESCUE/AMBULANCE SERVICE AT _____.

PATIENT COPY