

**COSHOCTON COUNTY EMS REFUSAL FORM**

EMS INCIDENT # \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_ Time \_\_\_\_\_

**(A) LEGAL CAPACITY**

Is Patient over 18? Yes \_\_\_ No \_\_\_ If minor, is patient married? Yes \_\_\_ No \_\_\_ If minor, is patient pregnant? Yes \_\_\_ No \_\_\_

**(B) MENTAL CAPACITY**

Disoriented to: Person? Yes \_\_\_ No \_\_\_ Possible ETOH/Drug Use? Yes \_\_\_ No \_\_\_  
Place? Yes \_\_\_ No \_\_\_ Admitted by Patient? Yes \_\_\_ No \_\_\_ Unsteady gait? Yes \_\_\_ No \_\_\_  
Time? Yes \_\_\_ No \_\_\_ Slurred speech? Yes \_\_\_ No \_\_\_

**(C) MEDICAL CAPACITY**

Head injury? Yes \_\_\_ No \_\_\_ Altered LOC? Yes \_\_\_ No \_\_\_ Abnormal glucose? Yes \_\_\_ No \_\_\_ READING: \_\_\_\_\_  
Abnormal pupils? Yes \_\_\_ No \_\_\_ Severe SOB? Yes \_\_\_ No \_\_\_ Abnormal SA02? Yes \_\_\_ No \_\_\_ READING: \_\_\_\_\_  
Vital Signs: B/P \_\_\_\_\_ Pulse \_\_\_\_\_ Respirations \_\_\_\_\_

This form is being provided to me because I have: (check all that apply)

- REFUSED ASSESSMENT                       REFUSED TREATMENT                       REFUSED TRANSPORT
- REFUSED EMS RECOMMENDED PROCEDURE OF \_\_\_\_\_

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 or EMS elected medical procedures, 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.

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 Coshocton County EMS (CCEMS), employees or other agents, and the medical command physician, 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 CCEMS or its crew, or the medical command physician.

*OTHER SPECIFIC INSTRUCTIONS OR CONCERNS TO PATIENT:* \_\_\_\_\_

\_\_\_\_\_

Signature of: Patient  Parent  Legal Guardian  \_\_\_\_\_ (MUST ALSO PRINT NAME) \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature & Printed Name \_\_\_\_\_ / \_\_\_\_\_

Crew Signature and Printed Name \_\_\_\_\_ / \_\_\_\_\_ 2<sup>nd</sup> EMS Crew Signature and Printed Name

**IF PATIENT REFUSES TO SIGN:** I attest that the patient has refused care and/or transportation by the emergency medical services providers. The patient was informed of the risks of this refusal and refused to sign this form when asked by the EMS providers.

\_\_\_\_\_  
Witness Signature                                      Relationship to Patient                                      Print Name