Jackson County Fire EMS Agencies Refusal Form

Patient Refusal for Assessment/Treatment/Transport

Agency Name:	Patient Name:	Patient DOB:

I ,_____, am the:

- Patient
- Legal guardian of the patient

I am refusing:

(Check the appropriate boxes)

- Assessment by the on-scene EMS provider
- Treatment by the on-scene EMS provider
- Transport by ambulance to the hospital
- Transport by ambulance to the recommended hospital for *Trauma* *STEMI* *Stroke* *Cardiac Arrest* *Diversion*

(Circle the appropriate recommendation)

Patient's Chief Complaint: _____

I understand and have been explained the potential consequences of my refusal, which include, but are not limited to: _____

_____

Signature of Patient/Guardian: _____

- Patient refused/unable to sign. Reason:_____

Witness Signature:_____ EMS Provider Signature: _____

Date: _____/_____/20_____ Time: _____:_____ PCR/Incident # _____

Jul 1, 2018