# South Plains Emergency Medical Services
## Refusal of Medical Treatment and/or Transport

Date _____ / _____ /_____ Service Number: _____ Call Location_____

Patient Name _____ D.O.B. _____/_____/_____ AGE_____

Patient Address _____ Phone ( ) _____ - _____

**PATIENT HAS BEEN INFORMED OF:**

| | Circle each that apply | |
|---|---|---|
| Their right to refuse treatment / transport. | YES | NO |
| Their condition may worsen and further injury may develop. | YES | NO |
| A delay in treatment may result in disability or death. | YES | NO |
| Injuries may not be apparent now, seek medical attention if problems occur. | YES | NO |
| The following injuries / conditions might exist or develop and that these can only be properly diagnosed & treated by a doctor at a medical facility: (SEE BELOW & CIRCLE ALL THAT APPLY) | YES | NO |

| | |
|---|---|
| Abdominal Injury | Heart Problems |
| Ankle Injury | Hip Injury |
| Arm Injury | Hand Injury |
| Back Injury | Head Injury |
| Breathing Problems | Infection |
| Burns | Internal Bleeding |
| Chest Injury | Knee Injury |
| Clavicle Injury | Leg Injury |
| Damaged Internal Organs | Neck Injury |
| Drug Overdose | Pelvis Injury |
| Ear Injury | Poisoning |
| Eye Injury | Rib Injury |
| Elbow Injury | Shoulder Injury |
| Facial Injury | Spine Injury |
| Fracture of Bone(s) | Stroke |
| Foot Injury | Wrist Injury |

**IMPORTANT**

**If any of the following occur, it may indicate a serious condition and you should seek immediate medical attention from a physician or call 911.**

| | |
|---|---|
| BLEEDING | HEADACHE |
| BLURRED VISION | INCREASED PAIN |
| CONFUSION | NAUSEA / VOMITING |
| DECREASED COORDINATION | NUMBNESS / TINGLING |
| DIFFICULT BREATHING | SWELLING |
| DIZZINESS | WEAKNESS |

**OTHER:**_____

_____

**OTHER CONDITIONS MAY OCCUR THAT ARE NOT LISTED HERE.**

I have fully explained the above to the patient and I do ☐ do not ☐ find obvious injuries or conditions that require medical evaluation. I believe that this patient has the present mental capacity to make the decision of not desiring (1) to be transported to a medical facility or (2) for medical treatment to be rendered.

Medic Signature: _____ Date _____ / _____ / _____ Time _____:_____

Medic Comments: _____

THIS IS A LEGAL DOCUMENT: I have been informed that I might have the afore mentioned injuries and / or conditions, and knowing that, and understanding fully what my condition is and having had the opportunity to ask questions about my condition, I STILL REFUSE MEDICAL TREATMENT OR AMBULANCE TRANSPORT for myself or minor who is my responsibility. By my signature I hereby release _____, its agents, employees, base hospital,and physician(s) from all liability or damages for illness or injury to myself (or minor child), including permanent disability and death.

Service Agency Provider

**CHECK THE APPROPRIATE BOX BELOW**

☐ I believe that I, or the minor(s) who is(are) my responsibility, have no injury or medical condition that requires transport or medical attention.

☐ My signature is declaration that I am an emancipated minor.

☐ My signature is declaration that I am a non-emancipated minor and my parent or guardian is not present or accessible to sign this document.

_____ ☐ Patient refused to sign.

Patient or Parent / Guardian

**LAW ENFORCEMENT OFFICER**

Witness _____ Witness _____ Witness _____

Address _____ Address _____ Address _____

Phone ( ) _____-_____ Phone ( ) _____-_____ Phone ( ) _____-_____