North Country EMS Patient Refusal/Treat in Place Form

Instructions to Provider: ***Complete form for all patients who are assessed and refuse care and/or transport.***
Complete form for all patients who are assessed and treated in place.
Complete all fields, enter N/A if Not Applicable.
Attach to paper PCR or scan for electronic attachment to ePCR.

Agency Name:

Date of Service: PCR#

Determination of Decisional Capacity:

- ☐ Altered mental status from any cause
- ☐ Age less than 18 unless an emancipated minor or with legal guardian consent
- ☐ Attempted suicide, danger to self or other, or verbalizing suicidal intent
- ☐ Acting in an irrational manner, to the extent that a reasonable person would believe that the capacity to make medical decisions is impaired
- ☐ Unable to verbalize (or otherwise adequately demonstrate) an understanding of the illness and/or risks of refusing care
- ☐ No legal guardian available to determine transport decisions

A patient, who is evaluated and found to have any one of the above conditions shall be considered incapable of making medical decisions regarding care and/ or transport and should be transported to the closest appropriate medical facility under implied consent.

Medical Control Criteria:

☐ Check to indicate if Medical Control was consulted

Physician Consulted:

Medical Control Instructions:

Medical Control consultation **is required** for the parent or legal guardian refusing transport of a child being evaluated for a Brief Resolved Unexplained Event (BRUE) (Previously referred to as an Acute Life Threatening Event [ALTE]).

Higher Risk Criteria:

Patients exhibiting the following "higher risk" criteria should receive particular attention for an appropriate evaluation and risk/benefit discussion prior to not transporting and the EMS provider may consider medical control consultation prior to obtaining a refusal or treat in place:

- Age greater than 65 years or less than 2 months
- Pulse > 120 or < 50
- Systolic blood pressure > 200 or < 90
- Respirations > 29 or < 10
- Serious chief complaint (including, but not limited to chest pain, SOB, syncope, and focal neurologic deficit)
- Significant mechanism of injury or high index of suspicion
- Fever in a newborn or infant under 8 weeks old

Provider Checklist

By signing, I confirm I have done the following:

- Determined the patient is able to understand the nature and consequences of the injury/illness and the risk of refusing care and/or transport or treat in place.
- Explained the risks of refusing care and/or transport for refusals. OR
- Explained the instructions for treat in place and left a copy of instructions with the patient.
- Advised the patient to seek medical attention and gave instructions for follow-up care.
- Confirmed that the patient understands these directions.
- Patient signed the Patient Refusal/Treat in Place form or documented why it was not signed.
- Left the patient in the care of a responsible adult when possible.
- Advised the patient to call 911 with any return of symptoms or if they wish to be re-evaluated and transported to the hospital.

Provider Name: _____ NYS EMT# _____

Provider Signature: _____

Reason for refusal of care and/or transport or treat in place. Provide directions for follow-up care:

Refusal of Treatment and/or Transport or Treat in Place

By signing the release, I agree that:

- I was advised to seek medical attention.
- I was made aware of how to access follow-up care and understand the directions given to me.
- I am being left in the care of a responsible adult when appropriate.

☐ I hereby refuse treatment and/or transport to a hospital. The risks of refusing care and transport were explained to me and this may increase the possibility of serious illness or death.

☐ I was treated in place and given a Patient Information Handout.

Follow-up Care:

If there is a return of symptoms or you become concerned, you should do one of thefollowing.

- Contact your primary care doctor or their on-call answering service.
- Call "911" and ask for an ambulance.
- Visit an Emergency Department or Medical Clinic.

Release

I hereby release such persons from liability for respecting and following my express wishes.

Name: _____ Date: _____

Signature: _____ Time: _____

Witness: _____ ☐ Patient refused to sign