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| ***REPLACE WITH YOUR MASTHEAD*** |
| **VFIS logo black JPG** | **SOG Title:** |
| **SOG Number:** |
| **Original Date:** | **Revision Date:** |
| **ABC Fire Department General Operating Guideline** |

**EMS Patient Refusal Checklist**

***This is a sample of a standard operating guideline (SOG) on this topic. You should review the content, modify as appropriate for your organization, have it reviewed by your leadership team and if appropriate your legal counsel. Once adopted, make sure the SOG is communicated to members, implemented and performance monitored for effective implementation.***

**Purpose:**

Patients don’t always act in their own best interest. Therefore, having a patient sign a refusal form is in the best interest of the emergency medical services (EMS) professional and the patient. In the event they don’t, documentation of the incident is warranted.

**Procedure:**

When patients refuse treatment and are unwilling to sign a release, document services by completing the attached form.

***This is a sample guideline furnished to you by VFIS. Your organization should review this guideline and make the necessary modifications to meet your organization’s needs. The intent of this guideline is to assist you in reducing exposure to the risk of injury, harm or damage to personnel, property and the general public. For additional information on this topic, contact your VFIS Risk Control representative.***

**References:**

VFIS EMS Patient Refusal Checklist



**EMS Patient**

**Refusal Checklist**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Date:

Location of Call: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Report #:

1. **Assessment of Patient** (Complete each item, circle appropriate response)
	1. Oriented to: Person? Yes No Place? Yes No Time? Yes No Situation? Yes No
	2. Altered level of consciousness? Yes No
	3. Head Injury? Yes No
	4. Alcohol or drug ingestion by exam of history? Yes No
2. **Medical Control**

\_\_\_\_\_ Contacted by: \_\_\_\_\_ Phone \_\_\_\_\_ Radio at \_\_\_\_\_ hours.

Orders:

\_\_\_\_\_ Indicated treatment and/or transport may be refused by patient.

\_\_\_\_\_ Unable to contact (explain in comments)

Orders:

\_\_\_\_\_ Indicated treatment and/or transportation may be refused by patient.

\_\_\_\_\_ Use reasonable force and/or restraints to provide indicated treatment.

\_\_\_\_\_ Use reasonable force and/or restraint to transport

Other:

1. **Patient Advised** (Complete each item, circle appropriate response)

Yes No Medical Treatment/evaluation needed.

Yes No Ambulance transport needed.

Yes No Further harm could result without medical treatment/evaluation.

Yes No Transport by means other than ambulance could be hazardous in light of patient’s present illness/injury.

Yes No Patient provided with refusal advise sheet.

Yes No Patient would not accept refusal advise sheet.

1. **Disposition**

\_\_\_\_\_ Refused all EMS services.

\_\_\_\_\_ Refused transport, accepted field treatment.

\_\_\_\_\_ Refused field treatment, accepted transport.

\_\_\_\_\_ Released in care of custody of self.

\_\_\_\_\_ Released in custody of law enforcement agency.

Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Officer:

\_\_\_\_\_ Released in care of custody: of relative of friend

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:

1. **Comments:** (use back of page, if additional space needed)

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Signature of Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Signature of Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: