

**Guam Fire Department Emergency Medical Services
Refusal of Care Form**



Patient's Name: _____ Date: _____

Incident #: _____ Incident Location: _____

Criteria for Refusing Care

The patient meets all of the following:

- Is an adult (18 or over), or if under 18, legally emancipated
- Is legally competent to make medical decisions
- Is oriented to Person, Place, Time, and Situation
- Exhibits no evidence of altered level of consciousness or alcohol or drug ingestion that impairs judgment
- Understands the nature of their medical condition, the risks, and consequences of refusing care.
- Able to communicate their wishes without undue influence

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

- Refused Transport
- Refused Medical Assessment
- Refused Medical Treatment (check all that apply) IV Access Oxygen Physical Exam Spinal Immobilization EKG Application Medications: _____ Other: _____
- Insisted on being transported to a hospital other than the facility recommended by EMS providers

Acknowledgment of Information

I have been offered an evaluation, medical care and/or transportation to a medical facility; however, I am refusing the services offered. I have been advised and understand the risks and consequences of refusing care/transport, including the fact that a delay in treatment and/or transport by means other than an ambulance could be hazardous to my health, and under certain circumstances, include disability and/or death.

Release of Liability

By signing this form, I am releasing the Guam Fire Department and the on-line medical control physician of any liability or medical claims resulting from my decision to refuse the transport, medical assessment and treatment offered.

I have read and understand the "Acknowledgment of Information" and "Release of Liability".

Patient Signature: _____ Refused to sign

Patient Representative Signature: _____ Refused to sign

Relationship (if not the patient): Lawful: Parent Guardian Conservator (pertains to child or dependent only)

<p>Patient Disposition Released in care of:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Law Enforcement <p>Agency: _____ Badge: _____ <input type="checkbox"/> Other: _____</p>	<p align="center">Instructions for Patient</p> <p>If the patient changes their mind, or condition changes</p> <ol style="list-style-type: none"> a. Call the local emergency number 911 b. Go to an emergency room in your area or c. Call your private doctor.
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Provider Signature: _____ Name (printed): _____

Witness Signature: _____ Name (printed): _____

Medical Control Physician: _____ Time Contacted: _____