

General Policy and Procedure

Refusing Treatment and/or Transport

- A. The nontransport Medical Information Report (MIR) / First Responder Run Report should be completed whenever patient contact is made and the patient is not transported. The MIR should also be completed when patient contact is made and patient is transported by other services (also see Medical First Responder Documentation). The circumstances of the response and reasons for nontransport should be clearly documented.
1. Transport Not Indicated: For circumstances when transport/treatment is clearly unnecessary document on the MIR or First Responder Run Report reasons why the transport was not indicated.
 2. Refusal of Indicated Treatment/Transport: When prehospital personnel feel that treatment/transport is indicated but the patient and/or parent/guardian is refusing, every effort should be made to inform the patient of the need for treatment/transport. If the patient refuses treatment or transport, the following must be documented:
 - a. Patient is of legal age (18) or parent/guardian must be present, or patient is an emancipated minor or married.
 - b. Patient is not incapacitated and is of sound mind and judgment is not impaired by drugs, alcohol or injury.
 - c. The patient should be informed in terms that they understand as to what risks can be reasonably associated with refusal.
 - d. Any alternatives to the recommended treatment/transport should be documented.
 - e. Efforts should be made to involve the patient's family to help insure that the patient understands the need for treatment/transport.
 - f. After the above conditions are met, ask the patient to sign the AMA release. If patient refuses to sign the release it still must be charted that conditions A-E were met. Legible signatures and addresses of competent witnesses should be obtained whenever possible.
- B. Medical Control may be contacted at any time to assist in the determination of the ability to refuse treatment or to help the patient understand the necessity of treatment/transport. Medical Control must be contacted for:
1. All pediatric refusals where the paramedic/MFR feels treatment/transport is indicated.
 2. All adult refusal patients appearing incompetent.
 3. When ALS treatment has been initiated.

MCA Approved	11/96	10/01		
Implement	10/97	01/02		

**WASHTENAW/LIVINGSTON COUNTY
MEDICAL CONTROL AUTHORITY/MEDICAL CONTROL BOARD
REFUSAL OF TREATMENT AND/OR TRANSPORT AGAINST MEDICAL ADVICE**

Date: _____ Run Number: _____ Patient Name: _____

1. I have refused the following services offered and recommended to me/the patient by _____ ("EMS Agency")

first aid care

treatment and/or transport to a medical facility

treatment and/or transport to the nearest or most appropriate hospital

2. I acknowledge that my refusal of services is against the advice of the EMS agency which has explained the benefits of receiving services to me. I have been advised of the possible dangers and risks to my/the patient's health in refusing those services including **death or endangerment of health** and/or the following dangers and risks which may be reduced or eliminated if services could be provided to me.

3. I have had the opportunity to ask questions about the risks and benefits of service and have had them answered to my satisfaction. I voluntarily and knowingly assume the risks and accept the consequences of my refusal of services. I hereby release the "EMS Agency" (Washtenaw/Livingston EMS System, Medical Control Authority and Medical Control Board), and any other fire unit, rescue unit or ambulance services, and their employees, agents, physicians, and affiliated health care providers from any liability for injury or ill effects that may result from my refusal of offered treatment and/or transport.

4. I have read (or have had read to me) and fully understand this document, including understanding the risks which I am assuming. All blank spaces were filled in and/or crossed out (as appropriate) prior to my signing below.

Date: _____ Time: _____ am/pm Signature: _____
[SIGNATURE OF PATIENT OR PERSON TAKING RESPONSIBILITY FOR PATIENT AND RELATIONSHIP]

Print Name: _____
(Relationship to Patient)

5. I declare that I have personally explained the risks and dangers to the person signing above.

Date: _____ Time: _____ am/pm Signature: _____
[SIGNATURE OF AMBULANCE SERVICE PERSONNEL WHO EXPLAINED RISKS]

Witness: _____ Address: _____
SIGNATURE

PRINT NAME