Form 100-4
Rev 1.0
Series June 2015

TRANSCARE EMERGENCY MEDICAL SERVICES
Refusal for Treatment or Transportation
(RF-02)

League /Event: _____ TYPE:_____

Location:_____ Incident :_____

Patient Name: _____ DOB: _____ Age:_____

Contact Details Landline: _____ Cell: _____

GUARDIAN: YES ☐ NO ☐ Landline: _____ Cell: _____

Name: _____ Age:_____ Relationship:: _____

Situation of Injury/Illness:

_____

_____

_____

Check Applicable Refusal

- ☐ Patient refuses treatment, transport is not necessary for the situation;
- ☐ Patient refuses treatment and transport to a hospital against EMS advice;
- ☐ Patient receives treatment does not desire transport to hospital by ambulance;
- ☐ Patient / Guardian believes alternative transportation plan is reasonable;
- ☐ Patient accepts transportation to hospital by EMS but refuses any or all treatment offered.
  Specify treatment refused:

  _____
  _____
  _____ _____

This form is being provided to me because I have refused assessment, treatment and/or transport by EMS personnel myself or on behalf of this patient. I understand that EMS personnel are not physicians and are not qualified or authorized to make a diagnosis and that their care is not a substitute for that of a physician.

I recognize that there may be a serious injury or illness which could get worse without medical attention even though I (or the patient) may feel fine at the present time. I understand that I may change my mind and call 911 or nearest community EMS available, if treatment or assistance is needed later. I also understand that treatment is available at an emergency department 24 hours a day.

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I acknowledge that this advice has been explained to me by the ambulance crew and upon affixing my signature for myself or on behalf of the patient signing this form, I am releasing Transcare Emergency Medical Services Management and employees and _____(Organizer) and it's employee of any liability or medical claims resulting from my decision to refuse care against medical advice .

Patient / Guardian

_____
Signature over printed Name

Events Organizer

_____
Signature over printed Name

Witness

_____
Signature over printed Name

Assign Medic Personnel

_____
Signature over printed Name

PCR: _____

DATE: _____

TIME: _____

"We Value Your Life"