INSTRUCTIONS FOR COMPLETING
THE CNYEMS PROGRAM PATIENT REFUSAL FORM AND INSTRUCTIONS.

The patient must meet the criteria set forth by the patient refusal protocol.

The CNYEMS Patient Refusal protocol does not allow a patient who is unable to understand the consequences of refusing care because their decision making ability is impaired by disease, injury or mind altering substances, to refuse treatment. Use of this CNYEMS Patient Refusal Form assume that you have determined that the patient (or parent) was alert, did not seem confused and was able to understand your explanation of the need for medical care and the risks of refusing it.

The EMS agency will keep the Patient Refusal Form.

The instructions will be given to the patient. Place an "X" in the space for the instruction being given. Review each part of the instructions given. Be sure to ask for any questions the patient may have regarding the instructions. You should review the instructions prior to completing the refusal form.

To complete the refusal form, enter the demographic information at the top of the form. Be sure to print all information legibly. The patient's name should be the same as on the PCR. Enter the PCR serial number (4-1234567) or run number provided by your agency if known at the time of the refusal. The date/time of service should be the date and time you are obtaining the refusal. Write out your agency's name; do not use acronyms (North Area Vol. Amb. Corps, not NAVAC). Print the CFR or EMT name and their EMT state certification number. If agencies use "IBM" numbers, they may be used in addition to the state certification number. Print the hospital contact and base station physician name if contacted. You are required to obtain medical control for using "Other" instructions.

The EMS personnel who is obtaining the refusal will enter an "X" in the appropriate spaces in the patient refusal or instruction section.

Patient Refusal: Complete this section if the patient is being treated and transported or if the patient has an injury or medical complaint and refuses transportation. Place an "X" in the appropriate space(s). If the patient is refusing specific medication, write the medication being refused in the space provided. If the patient is refusing a specific treatment not identified (flushing, splinting, bandage), list in the "other" section of the refusal form (not the Instructions section). Provider should check the appropriate box and have the patient sign on the Responsible Party line.

Instructions: Place an "X" in the space for the instructions being given to the patient. If "Other" is used, you must contact medical control for directions and instructions. Provider should check the appropriate box and have the patient sign on the Responsible Party line.

Statement Acknowledging Refusal and Receipt of NPP: Review Acknowledging the refusal and Notice of Privacy Practices have the patient or guardian sign and date the form.

Witness Statement: If a witness is available, have them read and sign the witness statement.

The Patient Refusal Form is to be attached to your PCR and maintained in accordance with your departments' policy and NY State EMS Code/Part 800.

If at any time there is a concern about the instructions you are providing, contact medical control.

CNY EMS Patient Refusal Form

Patient name:	PCR/Run#:
Date: Time:	EMS Agency name:
CFR/EMT name & number:	List base station physician contact-required for "Other" Instruction:

Patient Refusal

- ☐ Blood pressure and pulse checked
- ☐ To have an IV started
- ☐ Medicine(s): _____
- ☐ Neck collar and backboard
- ☐ Oxygen
- ☐ To be checked by the EMT's
- ☐ Other: _____

I refuse the above care the EMTs said I need.
Provider should check the appropriate box and have the patient sign on the Responsible Party line below.

Instructions

My signature below acknowledges that the EMTs have given me instructions that tell me what to do for the following problems:

- ☐ Universal Instructions
- ☐ Chest Pain
- ☐ Belly Pain
- ☐ Fever
- ☐ Respiratory Distress
- ☐ Extremity Injury
- ☐ Vomiting/Diarrhea
- ☐ Wound Care
- ☐ Headache
- ☐ Low Blood Sugar
- ☐ Back Pain
- ☐ Head Injury
- ☐ Insect Bite?Sting
- ☐ Seizures
- ☐ Fainting
- ☐ Other (contact Medical Control): _____

Provider should check the appropriate box and have the patient sign on the Responsible Party line below.

Statement Acknowledging Refusal and Receipt of Privacy Practices

I understand that I may have a condition that requires care by a physician. I understand that there may be a risk to my health if I do not seek medical care from a physician.

I the undersigned, acknowledge receipt of a complete copy of the Notice of Privacy Practices concerning the use or disclosure of my protected health information will be handled by the EMS Provider.

I **assume the risks and consequences** involved and **release** those offering to treat and/or transport me, as well as their employers, from any responsibility whatsoever for any unfavorable conditions or injuries caused by my refusal. I **refuse treatment and/or transportation** to a hospital. I forever **waive all actions and claims** by me or on my behalf resulting from my refusal or treatment and/or transpotation.

Responsible Party signature _____ Date _____

Witness Statement

I observed the above named person review and sign the statement above. The person was alert and did not appear confused. The person appeared to understand the statement and did not state otherwise.

Witness Signature _____ Date _____

Print Name _____

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