REFUSAL OF CARE

Must be Completed by Medical Personnel.

SULLIVAN WEST FIRE RESCUE

PATIENT MUST MEET THE FOLLOWING CRITERIA

1. An adult 18 years or older, or legally emancipated.
2. Oriented to Person, Place, Time and Situation.
3. Exhibits no evidence of:
   - Altered level of consciousness
   - Alcohol or drug ingestion that impairs judgment
4. Understands the nature of his or her condition, risks and consequences of refusing care.

PATIENT INFORMATION

Last Name:_____ First Name:_____

Home Address:_____

Date of Birth:_____ Medication:_____

Narrative:_____

_____

_____

ACKNOWLEDGMENT OF INFORMATION

I have been offered an evaluation, medical care, however:
I am refusing the services offered. I have been advised and understand the risks and consequences of refusing care, including the fact that a delay in treatment 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 Sullivan West Volunteer Fire Department of any liability or medical claims resulting from my decision to refuse medical are.

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

PATIENT SIGNATURE (X)_____ ❑ REFUSED TO SIGN

MEDICAL ATTENDEE:_____ CERTIFICATION: _____

WITNESSED BY (X)_____

DISPOSITION

❑ Released In Care/Custody Of Self ❑ Released In Care Of Parent/Guardian

❑ Released In Custody Of Law Enforcement Agency _____