

PEGOS VALLEY PUBLIC SERVICES

P.O. Box 488
200 W. First Street, #516
Roswell, NM 88203

REFUSAL FORM STANDARD

Date / Time:

Incident No.:

Location:

Alert / Oriented

Clear Judgment

No Suicidal Tendencies

Appropriate Vital Signs

Understands Risks Associated
with Refusal of Care

Age:

Patient: Name / Address / Phone

I have been assessed and/or treated for illness or injury by EMS. I have been advised and understand I may need further assessment and treatment by a physician. I have also been advised of possible signs and symptoms that my condition may be changing or that I have at least one potentially serious illness or injury, which needs further treatment. I REFUSE further treatment and transport by EMS, to the hospital of my choice in accordance with EMS protocols and/or medical direction. I also understand that signing this refusal does not preclude me from later obtaining medical care on my own, and/or requesting another EMS response.

Initial here

EMS has met with me, and I have told them I have no medical complaint, illness, or injury. I do not consider myself to be a patient. I have been advised and understand I may need further assessment and treatment by a physician. I REFUSE treatment, as well as transport by EMS to the hospital, consistent with EMS protocols and/or medical direction. I also understand that signing this refusal does not preclude me from later obtaining medical care on my own, and/or requesting another EMS response.

Initial here

I understand that EMS has made a good faith determination that I am alert, oriented and able to make decisions for myself. I have read, or have had read to me, the section above. My EMS assessment and my treatment options were explained to me and I understand them. I have no further questions of EMS at this time. I now knowingly and voluntarily release all individuals, organizations, and entities participating in and under the New Mexico Department of Public Safety EMS System from any liability for any and all claims arising from my decisions regarding my healthcare.

Translator / Witness

Patient / Guardian Signature