Patient Name: _____ Date: _____ Time: _____

Refusal of Screening Examination and Treatment

I, (the patient or parent/legal guardian of the patient listed above) understand that the hospital has a duty to provide care and has offered to:

- Perform a medical screening examination and determine if an emergency medical condition exists

Risk of Refusal: The risks associated with refusal have been explained to me by _____. These risks include, but are not limited to:
Name of Hospital Staff Member

- The medical condition may worsen and result in permanent disability or even death.
- ☐ Other (NONE if not checked): _____

Patient (or parent/legal guardian) Acknowledgement of Understanding:

- I understand that the hospital cannot provide treatment prior to performing a medical screening examination.
- I understand that by refusing the services offered I am doing so against the advice of the hospital staff.
- I also understand that the availability of medical services, including examination and stabilizing treatment, as well as necessary transfer to another facility, is not based on my ability to pay for these services.
- I have been given the opportunity to ask questions about the above information and my questions have been answered.
- I completely understand the consequences of my refusal.

_____ _____
Patient Patient's Parent/Guardian

_____ _____
Witness Date

☐ Patient refused to sign. Information on this form was discussed with the patient.

_____ _____
Witness Date

_____ _____
Witness Date

TO BE COMPLETED BY ED STAFF ON ALL PATIENTS REQUESTING TO LEAVE *BEFORE* MEDICAL SCREENING EXAMINATION IS COMPLETED:

Does the patient have a clinical presentation that suggests impaired capacity?
(including, but not limited to, head injury, intoxication, psychiatric illness, dementia, etc.)

☐ Yes ☐ No ☐ Unknown

If yes or unknown, facilitate evaluation by medical provider before allowing patient to leave.

If no: Encourage patient to remain for evaluation.

Documentation of interaction with patient:

_____

_____

_____

_____

_____

_____

_____

_____

☐ See ED record

_____ _____ _____

Name ***Date*** ***Time***