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

___________________________
Witness     Date

_________________________________ __________________________________
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.

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
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_________________________________________________________________________________
_________________________________________________________________________________

☐ See ED record

_____________________________________    ________________   _______________
Name             Date        Time