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# REFUSAL OF CARE FORM

The injured person must meet the criteria set forth by the Refusal of Care Protocol. The Protocol does not allow an injured person to refuse treatment unless the person meets all of the following criteria:

1. Is 18 years of age or over (or is accompanied by a legal guardian who can decide on the patient's behalf), and
2. Is oriented to Person, Place, Time and Situation, and
3. Shows no evidence of altered state of consciousness from injury or disease or use of alcohol or drug ingestion that impairs judgment, and
4. Understands the explanation of the need for medical care and the risks and consequences of refusing it.

The Trail Conference will keep the Refusal of Care Form and copies will be given to the injured and all appropriate entities, such as agency and park partner authorities.

## Instructions for Completing

The person(s) recommending and/or attempting to administer care fills out the Patient Assessment. The date and time should reflect the date and time the injured person refused care.

The injured person fills out the Patient Refusal.

Be sure to print all information legibly. If any party has questions or concerns when filling out this form, call the Trail Conference at (201) 512-9348.

## Patient Assessment

Patient Name:_____

Date:_____ Time:_____

### Legal Capacity

Patient over 18? ___Yes ___No

If a minor, does patient have a legal guardian present and representing their interest? ___Yes ___No

Comments/Quotes/Observations: _____

_____

*Note: If patient is a minor without a legal guardian they may not refuse care.*

### Mental and Medical Capacity

Is the patient disoriented to:

Person? ___Yes ___No Place? ___Yes ___No Time? ___Yes ___No Situation? ___Yes ___No

(*continued on next page*)

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Is there any indication of:

Head injury? ___Yes ___No  Slurred speech? ___Yes ___No  Unsteady gait? ___Yes ___No

Possible alcohol/drug use? ___Yes ___No  Auditory or visual hallucinations? ___Yes ___No

*Note: If "Yes" to any question about mental and medical capacity, the Patient may lack capacity to refuse care. Do not allow patient to sign form unless an explanation is noted or if patient is a minor and the form is signed by their legal guardian.*

Is the patient able to repeat understanding of their condition and consequences of treatment refusal?
___Yes ___No

Describe injury, treatment offered, consequences of refusal; and, names of witnesses present:

_____

_____

_____

_____

Signature of Person Recommending Care_____

Printed Name of Person Recommending Care_____

Witness Signature_____ Witness Printed Name_____

## Patient Refusal

Patient Name_____ DOB_____

Phone #_____ E-mail_____

Address_____

City_____ State_____ Zip_____

### Statement Acknowledging Refusal of Care

I, _____, recognize that I may have an injury or illness which could get worse without medical attention even though I (or the patient on whose behalf I legally sign this document) may feel fine at the present time. I also understand that there may be a risk to my health if I do not receive treatment and/or seek medical care. I acknowledge that this advice has been explained to me and I understand the potential harm to my health that may result from my refusal of the recommended care; and, I release the Trail Conference and supporting personnel from liability resulting from refusal.

Patient Signature _____

Patient Printed Name _____

Date _____