I. **PURPOSE**

To describe the procedure to be followed by prehospital and on-line medical control (OLMC) personnel when confronted with a patient who is an adult, an adolescent, or a minor who is refusing to be evaluated and/or treated by EMS responders; and/or to provide guidance in situations where parents, guardians or others are refusing service for anyone who appears to be in need of emergency care and/or transportation.

II. **DEFINITIONS for the purpose of this policy**

A. **Adult –** Person who has attained the age of legal majority (18 years)

B. **Adolescent –** An adolescent, for the purposes of this policy, is a person between the ages of 12 and 17, unless legally emancipated by reason of marriage, pregnancy, court order or entry into the United States Armed Forces. (M-3 IIB)

C. **Decisional capacity** means the ability to understand and appreciate the nature and consequences of a decision regarding medical treatment or foregoing life-sustaining treatment and the ability to reach and communicate an informed decision in the matter as determined by the attending physician (755 ILCS 40/10 [1996], as amended by P.A. 90-246).

Decisional Capacity is not a permanent designation. It can change and be influenced by medications, pain, time of day, depression, mood, delirium, and other factors. A patient may also have capacity to make some simple choices but not more complex treatment decisions.

The more significant the consequences of a decision, the greater the evidence of Decisional Capacity is required. It is not uncommon for patients who have a psychological diagnosis, are developmentally disabled, elderly, brain injured, non-verbal or non-compliant to have their Decisional Capacity questioned. Though none of these things directly implies or determines lack of Decisional Capacity, they do indicate the need for a careful assessment.

Decisional Capacity is not the same as Competency. A determination of Incompetency is permanent and decided by a court.

1. The **test of decisional capacity** is whether or not a patient understands their condition, the nature of the medical advice given, and the consequences of refusing to consent. This can be determined by the following assessments:

   a. **Affect**: Is the patient's behavior consistent with the environmental stimuli?

   b. **Behavior**: Is the patient able to remain in control?

   c. **Cognition/judgment**: Does the person understand the relevant information? Do they have the ability to manipulate the information? Can they draw reasonable conclusions based on facts? Can they communicate a choice?

   d. **Insight**: Can the patient pull all of these together to appreciate the implications of the situation and the consequences of their decision?

2. Decisional capacity could be impaired by the presence of hypoxia, shock/trauma; drug or alcohol intoxication; unusual behavior; or mental illness.

D. **Minor –** A minor, for the purposes of this policy, is a child aged 11 or less

E. **Multiple Release –** Two (2) or more persons present at one incident without illness, injury or complaint who are refusing assessment, care, and/or transportation

F. **Patient** – Person with any sort of complaint, possible illness, or mechanism of trauma that could suggest injury (Policy A-1)

III. **Elements of granting or withholding consent**

A. **At common law, an adult with decisional capacity must consent before medical treatment is rendered.** Every decisional adult has the right to the possession and control of his own person, free from all restraint or interference of others unless care is indicated by clear and unquestionable authority of law.

B. A decisional adult **has the right, arising out of the constitutional right of privacy, to refuse treatment, even if doing so will result in serious consequences or death**. The right to refuse medical care expressed while competent (decisional) and proven by clear and convincing evidence must be honored even if the patient later becomes incompetent or non-decisional.

C. There is a legally recognized "right to die" unless a compelling state interest overrides the rights of the patient. **The state has four interests which may override the individual's freedom to decide:**

1. Preservation of life; although this has evolving interpretation,
2. Protection of innocent third parties,
3. Preservation of the ethical integrity of the medical profession, and
4. Prevention of suicide.

D. Any unpermitted, intentional touching of a decisional adult patient's person constitutes the tort of **assault and battery** (Southwick, 350).

E. An effective consent or refusal for a high-risk procedure should be **"informed"**

1. EMS personnel should clearly explain the proposed treatments to the patient and when appropriate, the family.

2. The explanation shall include a **disclosure of risk**

   a. Nature of the illness/injury
   b. Nature, purpose and need for the recommended examination/care
   c. Potential benefits and possible risks and complications of recommended treatment; plus possible results of non-treatment
   d. Any significant alternatives if they refuse recommended treatment

3. Risks that are remote and improbable can generally be omitted from the EMS disclosure of risk as not material or important to the patient's decision. The System disclosure of risk statement is framed as the "Medical Miranda" on the Refusal of Service form.

F. **Emergency doctrine (implied consent):** An emergency eliminates the need to obtain consent, since the law values the preserving of life and the prevention of permanent impairment to health. This rule applies only when the patient is incapable of expressing consent by reason of unconsciousness, mental incompetence, or legal disability. It further applies only when the person legally authorized to consent for the incompetent patient is similarly incompetent or unavailable (Southwick, 375).

Ill. Rev. Stat. 410 ILSC 210/3 provides that treatment may be rendered to minors if "the obtaining of consent is not reasonably feasible under the circumstances without adversely affecting the condition of such minor's health." (M-3 IIA).

The "emergency doctrine" extends to virtually any medical procedure necessary to preserve the life or health of a patient. However, "where a patient is in full possession of all his mental faculties and in such physical health as to be able to consult about his condition," the patient's consent is required (Barnes v Hinsdale Hospital).

IV. **POLICY**

A. **Who can consent to and/or refuse assessment/care?**

1. The consent of a decisional adult, parent, legal guardian, or of someone authorized to act for a non-decisional or legally incompetent patient (surrogate/Durable Power of Attorney), must be obtained before any medical treatment is undertaken, unless an emergency justifies treatment under implied consent.

2. Any party who has the legal authority to consent to treatment has the authority to refuse medical care.

B. **Situations where consent can be thorny and possibly disputed**

1. **Treatment of adolescents and minors:** This policy applies.

2. **Persons judged to be non-decisional by EMS and OLMC personnel:** This policy applies.

3. **Multiple persons at one incident** refusing care that have no apparent illness or injury: This policy applies.

4. **Incompetents:** If a patient has been adjudicated an incompetent through court proceedings, there will typically be a guardian, a trustee, or a conservator who will have legal authority to grant consent for treatment.

5. Terminally ill patients with **DNR orders**: **Policy D-5 DO NOT RESUSCITATE GUIDELINES**/Withdrawing or Withholding Medical Treatment.

6. Non-decisional patient who has designated another with **Durable Power of Attorney for Healthcare – See Policy D-5.**

7. **Religious beliefs:** If there is any question about the legality or medical implications of allowing an adult to refuse life-saving emergency care because of the patient's personal convictions or religious beliefs, contact OLMC.

8. **Prisoners in custody:** If a prisoner is non-decisional, they can be treated under implied consent. If the prisoner is competent, the prisoner does not lose the right to make decisions regarding medical treatment. Law enforcement agents cannot compel healthcare personnel to act in disregard of the rights of any person, regardless of whether or not such person is in police custody. If a police officer denies treatment of a prisoner that appears medically indicated, provide the officer with full disclosure of risk and attempt to gain their cooperation. Contact OLMC and have the officer speak directly with a physician.

9. **Persons with mental illness:** If EMS personnel or family members have first hand knowledge and reasonably suspect that a patient who is refusing care/ transportation is mentally ill and because of their illness would intentionally or unintentionally inflict serious physical harm upon themselves or others in the near future, is mentally retarded and is reasonably expected to inflict serious physical harm upon himself/herself or others in the near future, or is unable to provide for his or her own basic physical needs so as to guard himself or herself from serious harm and needs transport to a hospital for examination by a physician (Ill Mental Health Code) they shall complete a **Petition Form** and **follow System Policy E1:** Emotional Illness and Behavioral Emergencies.

C. **Refusal contraindications -** Instances when EMS personnel should not accept a refusal from an adult, adolescent, or a surrogate:

1. Patient is homicidal, suicidal, meets one of the criteria above under persons with mental illness, has altered mental status (AMS), drug altering behavior, or is hypoglycemic or hypoxic.

2. Adolescents may not refuse an assessment to determine if they are ill or injured or care if they are ill or injured.

3. Refusal of care for a minor, adolescent, or non-decisional adult by a parent, guardian, agent, or surrogate is not *necessarily* valid. The welfare of the patient is the EMS System's primary consideration. If EMS personnel believe that the patient's health and welfare could be compromised by the refusal, they must contact OLMC before accepting and executing a refusal of service. Each case must be evaluated on its own merits to determine a proper course of action.

V. **PROCEDURE**

A. If a mechanism of illness/injury exists or a request has been made on an individual's behalf for examination and treatment, **each person must be provided** an **appropriate screening exam**, to the extent authorized in an attempt to determine whether an emergency medical condition exists. (C-4 IA)

1. Before executing a refusal, assess and document the following unless impossible to obtain:

   a. Decisional capacity; mental status; lack of impairment from alcohol, drugs, disease
   b. Vital signs
   c. Past medical history
   d. Physical exam findings: glucose level, pulse oximetry; capnopgraphy number & waveform, ECG if indicated

2. **EMS personnel have a duty to attempt to convince a patient to receive needed care.**

B. Refusals for patients who have received or are candidates to receive **BLS** care may be processed by two EMTs.

C. Refusals for patients who have received or are candidates to receive **ALS** care must be processed by two Paramedics or PHRNs unless an exception applies (e.g., ALS non-transport vehicle). **See Policy M-9: MedEngines** (non-transport vehicles).

D. **ADULT PATIENT with DECISIONAL CAPACITY**

1. If a decisional adult steadfastly refuses assessment, care, and/or transportation, they must be provided with disclosure of risk. Advise the patient of their medical condition as known by the facts available and explain why care and/or transportation is advised. Continue to encourage consent if the patient is undecided or if you believe he or she may change his/her mind, as many people who initially refuse emergency services are actually in need of such care.

2. Each person refusing some aspect of recommended EMS assessment, care, and/or transportation should be asked to attest to what they are refusing by checking all the relevant section(s) on the NWC EMSS Release of Liability form and note their withholding of consent by signing the form (paper or electronic) – see steps below.(C-4 IC).

E. **PATIENT LACKING DECISIONAL CAPACITY**

1. If the behavior and/or medical condition of the patient suggests lack of decisional capacity and impairment due to intoxication, chemical abuse, hypoxia, etc. so that the patient is unable to refuse treatment and/or transportation, efforts should be made to explain to the patient the potential seriousness of his/her condition, the possible consequences of refusing treatment, and the necessity of transporting them to the hospital. An impaired and/or non-decisional patient is NOT legally able to make healthcare decisions.

2. If efforts to gain the patient's cooperation are unsuccessful or they are combative, refer to the Psychological Emergencies SOP and System Policy E1-Petitioning an Emotionally Ill Patient which includes the System procedure on **indications for sedation** and/or use of **restraints**.

3. A patient lacking decisional capacity must have their rights protected and shall be transported to the nearest appropriate hospital for evaluation.

4. **Special requests of a guardian or family member will be considered on a case-by-case basis and must be approved by OLMC, based on the**

   a. patient's medical stability and the potential harm which could be incurred due to prolonged transport to other than the nearest appropriate hospital; and

   b. individual EMS Provider's Policies.

F. **ADOLESCENTS**

1. Having been called to administer care to an adolescent, the duty of EMS personnel is to determine the nature of the health problem and institute appropriate treatment. (M-3 IIIA)

2. **Adolescents that may consent to or refuse healthcare interventions (M-3 IIC)**

   a. In Illinois, a person under the age of 18, may not consent to, or refuse, treatment and/or transportation with limited exceptions as listed below.

   b. **Instances in which an adolescent may legally consent to or refuse treatment**:

      (1) Married at the time treatment is rendered
      (2) Pregnant at the time treatment is rendered
      (3) Requesting treatment for sexual assault or abuse, a sexually transmittable disease, alcohol or drug abuse or limited out-patient mental health counseling
      (4) Member of the United States Armed Services
      (5) Emancipated by court order

   c. **NWC EMSS Policy:** If an adolescent appears to be exhibiting rational behavior with decisional capacity, and based on the EMS assessment there is **no apparent illness or injury**, EMS can seek OLMC authorization to honor the adolescent's refusal of service and release the adolescent to the circumstances in which EMS personnel found him or her, unless releasing the individual would place them at risk of harm. See procedural steps below.

3. **Parent/guardian ON scene:** Steadfast refusal by an adolescent with decisional capacity to accept recommended treatment and/or transportation shall be discussed with a parent or other legally responsible adult (e.g., guardian or caretaker with authority to act on behalf of the parent) while EMS personnel are on the scene. If treatment appears necessary, the responsible adult should be informed and consent for treatment solicited from them. (M-3 IIIC) An adolescent cannot refuse care and/or transportation that is consented to by the parent/guardian unless they are emancipated as listed above. If treatment/transportation appears unnecessary, the adult may sign the refusal form on behalf of the adolescent.

4. **Parent/guardian NOT on scene:** If the parent or responsible adult is not present, EMS personnel must attempt to contact them by phone from the scene BEFORE treatment is begun (unless emergency doctrine applies) or the adolescent is released.

   a. **If phone contact is established and treatment appears necessary**, the responsible adult should be informed about the adolescent's condition and verbal consent for treatment solicited from them. (M-3 IIIC)

   b. **If phone contact is established** a**nd treatment/transportation appears unnecessary,** the adult may give verbal authorization for refusal of service on behalf of the adolescent. This refusal of service must be thoroughly documented on the ePCR and the refusal confirmed with OLMC.

   c. **If unable to establish contact from the scene,** and an adolescent with decisional capacity is refusing care/transport and the EMS assessment determines that they are **not ill and/or there is no apparent injury** and no foreseeable harm will come to the adolescent as a result of not receiving immediate care and/or transportation:

      (1) EMS must contact an ED OLMC physician at the nearest System Resource or Associate Hospital from the scene BEFORE the adolescent is released, the situation described, and a course of action prescribed.

      (2) OLMC shall consider allowing the adolescent to be released on their own signature. The circumstances of the call must be thoroughly documented on the patient care report (PCR) and Communications Log, and must be verified by witnesses. (M-3 IIID)

      (3) EMS shall attempt to contact the parent/guardian again, as soon as possible after return to the ambulance quarters.

      (4) **Follow up notice**: If no contact can be made with a parent or guardian during that shift, a follow-up letter, on a form created by the NWC EMSS, must be sent to the parent/guardian immediately thereafter, describing the circumstances of the call, the nature of the evaluation, including any other information that the scene personnel deem significant so the parent/guardian is aware of an EMS response for their adolescent. A copy of this letter should be scanned and added as an attachment to the electronic PCR.

G. **MINORS**

1. Having been called to administer care to a minor, the duty of EMS personnel is to determine the nature of the health problem and institute appropriate treatment.

2. Minors age 11 or less may not give nor withhold consent for EMS assessments or care. Consent must be obtained from a parent or legal guardian unless the emergency doctrine applies and treatment is rendered under implied consent.

3. **Parent/guardian ON scene:** Steadfast refusal by a minor with decisional capacity to accept recommended treatment and/or transportation shall be discussed with a parent or other legally responsible adult (e.g., guardian or caretaker with authority to act on behalf of the parent) while EMS personnel are on the scene. If treatment appears necessary, the responsible adult should be informed and consent for treatment solicited from them. A minor cannot refuse care and/or transportation that is consented to by the parent/guardian. If treatment/transportation appears unnecessary, the adult may sign the refusal form on behalf of the minor.

4. **Parent/guardian NOT on scene:** If the parent or responsible adult is not present, EMS personnel must attempt to contact them by phone from the scene BEFORE treatment is begun (unless emergency doctrine applies) or the minor is released.

   a. **If phone contact is established** and treatment appears necessary, the responsible adult should be informed about the minor's condition and verbal consent for treatment solicited from them. (M-3 IIIC)

   b. **If phone contact is established** and treatment/transportation appears unnecessary, the adult may give verbal authorization for refusal of service on behalf of the minor. This refusal of service must be thoroughly documented on the ePCR and the refusal confirmed with OLMC.

   c. **If unable to establish contact from the scene:** The minor must be assessed and treated as necessary and transported to the nearest appropriate hospital using usual and customary practices for OLMC.

H. **Protective custody:** If, in the judgment of EMS personnel or OLMC, the adolescent does not have decisional capacity and/or the responsible adult (parent or guardian) purporting to act on behalf of the adolescent or minor is withholding consent for necessary care/transportation and there is foreseeable risk of harm to the adolescent or minor in withholding care/transportation, consideration must be given to having a local police officer or OLMC physician take protective custody of the adolescent/minor in order to render necessary care (reference Illinois Child Abuse and Neglect Statute Program). In all such cases, attempts should be made to gain the cooperation of the adolescent and/or the parent/guardian. Early contact must be made with a System Resource or Associate Hospital. (M-3 IIIB) EMS personnel should initiate resuscitative treatment and transport to the nearest appropriate hospital. Consideration should be given to reporting possible Child Abuse or Neglect to the Department of Children and Family Services per SOP.

I. **Multiple Releases**

1. If EMS personnel have been called to a scene with multiple potential patients and a mechanism of illness/injury exists, each individual must be provided an appropriate screening exam, to the extent authorized by the person, in an attempt to determine whether an emergency medical condition exists.

2. If more than one adult with decisional capacity steadfastly refuses assessment, care, and/or transportation AND there is no apparent illness/injury– their refusal of service can be grouped on one Patient Care Report and processed as a Multiple Release.

3. **If the incident involves a School Bus, follow the Region IX School Bus Incident Policy and Procedure.**

4. Each person refusing assessment, care, and/or transportation must be provided with disclosure of risk and asked to sign the NWC EMSS Release of Liability form (paper or electronic).

5. The person shall be advised as to the procedure for obtaining a printed copy of the release form.

6. **HIPAA forms:** Each of these persons MUST receive the Health Insurance Portability and Accountability Act (HIPPA) Notice of Privacy Practices in compliance with local agency policy. (C-4 IIB2)

VI. **On Line Medical Control (OLMC) for Refusals(R-6 IVD)**

A. On-line medical control contact with the nearest system Resource or Associate hospital must be made while ON THE SCENE BEFORE the individual is released to appropriately discharge the EMS provider's duty to the patient(s).

B. ALL patients refusing care and/or transportation who have received, or are candidates to receive, ALS care must be called in on the UHF radio/cellular phone line that can be recorded.

C. BLS patients refusing care and/or transportation in whom a high risk potential exists are to be called in on the MERCI (VHF) radio. If no MERCI (VHF) radio is available, a standard phone line may be used.

1. **The following BLS refusals must be called in:**

   a. All minors (legal definition) 17 years of age or less;
   b. All persons 65 years or older;
   c. Patients with altered mental status who cannot comprehend the risk of refusal decisions, abnormal VS, breath sounds, SpO_2 or capnography readings;
   d. Obstetrical patients;
   e. Patients meeting level I and/or II trauma triage criteria based on the SOPs;
   f. Patients under the influence of drugs or alcohol;
   g. Patients with psychological/behavioral complaints; or when
   h. EMS personnel have doubts about the appropriateness of the refusal.

2. OLMC is not required for BLS adult patients (ages 18-64) refusing care and/or transportation who are alert, hemodynamically stable, and do not meet one or more of the above criteria.

VII. **IF A REFUSAL IS CHALLENGED OR QUESTIONED BY OLMC**

A. In all instances where EMS personnel or an ECRN questions the patient's decisional capacity or has just cause to suspect that the patient may sustain harm due to the lack of medical evaluation/care and do not believe that the refusal should be honored, the ECRN shall immediately inform an on-duty physician. The physician shall personally assume control of the call and shall speak directly to the patient over the radio or phone.

B. If, in the judgment of the physician, the patient does not need to be brought in against their will, EMS personnel shall release the patient following standard procedure. OLMC personnel shall fully document the facts as presented by EMS, the statements made by the patient, and confirm that the patient had been fully informed of the risks inherent in refusing care and/or transportation and understood the consequences of their decision. **The refusal shall be documented as Against Medical Advice (AMA).**

C. If the ED physician believes that the patient lacks decisional capacity to refuse care and/or transportation, the patient shall be transported against their will.

VIII. **Documenting a Refusal of Service (R-6 IIIC)**

CAREFUL DOCUMENTATION IS ESSENTIAL!! The best defense to a disputed refusal is a thoroughly documented PCR and Refusal Form.

A. EMS personnel should enter the incident number (if known) and location into the ePCR. Obtain the **required demographic** information including the patient's name, home address, date of birth, gender, and phone number.

Document the following on the PCR: patient's decisional capacity, the extent or limitations of the EMS assessment; patient understanding of the EMS impression and all attempts to convince the patient to receive care; any EMS concerns about the refused interventions or transport; disclosure of risks and benefits provided to the patient; state clearly if the refusal is being executed AMA; and state that the patient was instructed to seek medical care if their condition changes.

B. **Execution of the Refusal Form**

1. If using the paper Refusal form, EMS personnel should complete the top two lines of the form, noting the EMS Agency's name, date, incident location and number (if known).

2. Electronic form: C**lick on the Refusal of Service tab** within the report; then **click** on the **check box next to Click for Refusal of Service.** This activates the refusal form.

C. Inform the patient/guardian of the risks inherent in refusing care and/or transportation. Convey, and**/**or allow the patient to read the **"Medical Miranda"** located under Patient Refusal of Service in the Refusal of Service tab, or on the Release of Liability form:

"I (or my guardian) have been informed regarding the state of my present physical condition to the extent I allowed an examination, and I (or my guardian) hereby refuse to accept such medical care and/or transportation as recommended by representatives of the EMS System listed above. I (or my guardian) do hereby for myself, my heirs, executors, and administrators and assigns forever release and fully discharge said EMS System, its officers, employees, medical consultants, hospitals, borrowed servants or agents from any and all conceivable liability that might arise from this refusal of care and/or transportation, and I (and my guardian) therefore agree to hold them completely harmless.

I (or my guardian) have been informed that a refusal of care and/or transportation for an evaluation my cause me to suffer pain, disability, loss of function, worsening of my condition, or even death as a result of my illness/injury. As a competent adult, I (or my guardian), fully understand al of the above, and am/is capable of determining a rational decision on my own behalf.

D. The patient or agent must initial (**on the printed form**), or attest as **I Agree or I Disagree** on an electronic medium to **each of the specific statements** that apply to the situation. **Not** Applicable should be checked for any statements that do not apply to the situation.

The following statement, *"I have been instructed to contact a physician for an examination and/or treatment if my condition changes in any way",* **must be initialed or acknowledged electronically by every patient** refusing care and/or transportation.

E. **Patient signature**: EMS personnel must have the patient or their agent sign the Release of Liability form on the line provided as a final mechanism of documenting their refusal of care and/or transportation. Electronic signature capture is acceptable. **Electronic signatures should be time stamped by clicking on the clock icon next to the signature area.**

F. If a patient refuses to sign the Release form, the "Refusal to Sign a Release Statement" must be checked and witnessed by at least two EMS personnel.

G. There must be at least two witness signatures on the electronic release or printed form. One must be the EMS provider who provided disclosure of risk and is responsible for obtaining the patient/guardian's signature on the form. The other may be a second crew member or a police officer who can verify that the person refused care and/or transportation, was given full disclosure of risk and still steadfastly refused service.

H. **Instructions for completing the electronic version of the Refusal Form:**

1. Click on the button containing the name of the crew member who will be the primary witness and scroll down to the statements listed below the button.
2. There is a section indicating the patient refused to sign; a section acknowledging the patient received the Notice of Privacy Practices (HIPAA) statement and a section witnessing the refusal of Service.
3. The crew member should click the "I agree" to the appropriate choice(s). Do not click on sections that do not apply.
4. Crew members should sign in the signature box and then click on the clock below to time stamp their signature
5. Click the Save Signature button. The section will close and they will see a check mark next to their name.
6. The second witness is done the same way
7. If the second person is not listed, the crew member should click on the Add Signature button.
8. The dialogue box will open as before. There is an area to type in the person's name (directly below the signature box).
9. The second signature should also be time stamped.
10. Once all three signatures have been recorded and time stamped:
    a. Click on the Lock Refusal of Service button at the bottom of the screen.
    b. This does not lock the entire report, merely the refusal section.
11. Call information is to be entered into the EMS Field software whether on the scene, at a System hospital or at a Provider's facility as soon as possible, but no longer than two hours after the incident, unless there are extenuating circumstances and no later than the end of the provider's shift. (C-4 IIB3)

I. **Form distribution:** If using a printed ~~multi-copy~~ form, ~~provide the patient/agent with the original and~~ retain the original signed copy ~~second (yellow) copy of~~ for the EMS agency's records It should be scanned and added as an attachment to the electronic PCR. Inform the patient/agent that a copy of the form is available from the EMS agency upon their written request and give them contact information.

J. **Printed form acquisition:** The print edition of the Refusal form is available in English and Spanish. Both are posted to the System website (www.nwcemss.org) under the Policy Manual tab associated with this policy. They may be duplicated for use by an EMS Provider Agency without change to any of the language.

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Reference: Southwick, A.E. (1988). *The law of hospital and health care administration*, second ed. Ann Arbor: Health Administration Press.

EMS REFUSAL OPTIONS

Called to Scene

Persons present				**Persons not present**
Mechanism of illness/injury possible			**NO mechanism of illness/injury** Called by mistake	**NO mechanism of illness/injury** Called by mistake
Adult **Apparent Illness/Injury** Decisional and refuses care: Attempt to assess/provide care to the extent allowed by patient Provide full disclosure of risk; have patient sign refusal form; contact OLMC from scene. Note if refusal is AMA. ePCR required.	**Adult** **Apparent Illness/Injury** Non-decisional or incompetent pt refuses care: CANNOT REFUSE; contact OLMC from scene. May need to sedate/restrain pt to provide emergency care and transportation. ePCR required.	**Adult** **No apparent illness/injury:** Decisional and refuses care: Provide full disclosure of risk; have patient sign refusal form; contact OLMC from scene. ePCR required. Consider if Multiple Release applies	**Adult** **Decisional and refuses assessment/care** **Considered a no patient contact** No refusal form or ePCR necessary for EMS System.	**No patient contact** No refusal or PCR necessary for EMS System

Called to Scene

Adolescent or minor child present: Mechanism of illness/injury possible			
Adolescent **Apparent Illness/Injury** **Parent on scene** Provide care to the extent allowed by parent Adolescent cannot refuse unless emancipated Contact OLMC from scene ePCR required	**Adolescent** **Apparent Illness/Injury** **Parent NOT on scene** Attempt to contact parent/guardian **Contact made**: Follow parent's wishes **No contact made**: Adolescent cannot refuse unless emancipated Contact OLMC from scene. May need to sedate/restrain pt to provide emergency care and transportation. ePCR required.	**Adolescent** **No apparent illness/injury:** Decisional and refuses care: Attempt to contact parent/guardian **Contact made**: Follow parent's wishes **No contact made**: Contact OLMC from scene to OK refusal Provide pt w/ full disclosure of risk; have patient sign refusal form ePCR required. Reattempt contact w/ parent No contact: Send follow up notice	**Minor** **No apparent illness/injury:** If parent on scene or contacted by phone: follow parent's wishes **No parent on scene and/or cannot contact:** Contact OLMC from scene. Treat and transport child. They cannot refuse. **Apparent Illness/Injury** Parent cannot refuse life-saving care – consider need for protective custody

Final word: WHEN IN DOUBT, DO THAT WHICH IS LEAST LIKELY TO CAUSE HARM.