City of Kissimmee Fire Department

Refusal of Medical Care/Transport Checklist

Patient # ___ of ___

- ☐ Patient/Custodian is awake, alert, and oriented to person, place, time, and events
- ☐ Patient/Custodian is not exhibiting signs or symptoms of a medical condition that may impair their capacity to make an informed decision:
  - Does not appear intoxicated, or under the influence of any substance that would impair their ability to make an informed decision
- ☐ Gait and coordination are apparently normal, or at baseline
- ☐ Speech is clear and appropriate, or at baseline
- ☐ Expresses good insight into the nature of their condition, and has a plan to deal with the problem
- ☐ Patient is not exhibiting evidence of a psychiatric decompensation:
  - No suicidal or homicidal thoughts or actions
  - No delusions, hallucinations, or bizarre behavior
- ☐ Patient/Custodian has been advised of the risks of refusing transport to the hospital or specific treatments offered (including permanent disability, injury to self/others and death when appropriate)
- ☐ Patient/Custodian understands and accepts the risks of refusal
- ☐ Patient/Custodian understands to re-contact 911 should he/she change their mind and desire transportation to the hospital
- ☐ Patient/Custodian has been advised to contact their primary care physician, or otherwise seek medical attention, as soon as possible

☐ **Vitals: B/P**:_____ **Pulse:**_____ **Resp:**_____

☐ **Injuries (if any)**:_____

☐ Is the Patient a Minor? Yes_☐_No_☐____

☐ Has the Parent been notified? Who was contacted?_____

I hereby refuse treatment at scene and/or transport to a medical facility and I acknowledge that such treatment was advised by Kissimmee Fire Department personnel. I hereby release such persons from liability for respecting and following my expressed wishes and directions. I authorize the sharing of my medical information with the Osceola County Health Department. I understand that I may be contacted by the Health Department regarding the medical services rendered.

Patient Name (Print): _____

Patient Signature:_____Date: _____

If patient is a minor, obtain the following:

Parent/Custodian Name (print): _____

Parent/Custodian Signature:_____Date: _____

***Paramedic Name (print): _____

***Paramedic Signature:_____Date: _____