

The following “Informed Consent to Refuse Examination, Treatment of Transfer” form is discussed in the AMA introduction letter written by Dr. Charles Grassie. The background article, found in this AMA section of this BPG Manual, supports use of this form as dictated by EMTALA. Note that the physician should fill out this form even if the patient refuses to sign it and it should become part of the permanent record.

It is necessary for the Emergency Department Medical Director to make sure this type of form is available in your department and that it is being utilized appropriately. If your department does not currently have a refusal form then copies of this sample should be made.

# Informed Consent to Refuse Examination, Treatment or Transfer

## I understand that the hospital has offered: (Check all that apply.)

- A.  To examine me (the patient) to determine whether I have an emergency medical condition, or
- B.  To provide medical treatment or to provide stabilizing treatment for my emergency condition (AMA), or
- C.  To provide a medically appropriate transfer to another medical facility.

The hospital and physician have informed me that the **benefits** that might reasonably be expected from the offered services are:

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And the **risks** of refusing the offered services are:

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## Physician Documentation

- The patient appears competent and capable of understanding risks.
- Alternative treatments discussed with the patient.
- Patient's family involved.     Family not available.     Patient does not want family involved

Signature of Physician \_\_\_\_\_

I understand that if I refuse the offered services, I am doing so against medical advice. I understand that my refusal may result in a worsening of my condition and could pose a threat to my life, health, and medical safety. I understand I am welcome to return at any time. I choose to refuse the offered services.

Signature/Patient or Legally Responsible Person \_\_\_\_\_

Print Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State/Zip \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Witness/Signature \_\_\_\_\_ Print Name \_\_\_\_\_

Patient or person legally responsible for patient was offered but refused to sign form after explanation of their rights and the risks/benefits of the services offered:

Hospital representative who witnessed refusal to sign \_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_