STAT MEDICAL TRANSPORT

REFUSAL OF SERVICES

Name _____

Address _____

City _____

State _____ Zip _____

Phone _____

Patient Name: _____ SS#: _____

Date of Birth: _____ Date: _____

EMS Unit #: _____

DETERMINATION OF A MINOR

In Pennsylvania a minor (under the age of 18) is considered emancipated and is able to give consent for their own medical treatment if:

1. They have graduated from high school.
2. They have ever been married.
3. They have ever been pregnant.
4. They live financially independent from their parents. (NOTE: This determination is obviously difficult to make – Consult Medical Command.)

In addition, any person 14 years of age or older who believes he/she is in need of treatment for mental illness may consent to examination and treatment.

PLEASE READ AND SIGN THIS FORM!

This form has been given to me because I have refused evaluation, treatment, and/or transportation by the Emergency Medical Services (EMS) providers. My health and safety are the primary concern of the EMS providers, so even though I have decided not to accept EMS assistance, I have been told and understand:

1. The evaluation and/or treatment provided by an EMS provider is not a substitute for medical evaluation and treatment by a doctor. **WE ADVISE YOU TO GET MEDICAL EVALUATION AND TREATMENT IMMEDIATELY.**
2. When medical treatment is needed, it is usually better to get it right away. My condition may be worse than it seems to me. Without treatment, my condition or problem could become worse. A delay could make my condition or problem worse or result in **permanent disability and/or death.**
3. If I change my mind or my condition becomes worse and I decide to accept treatment and transport by Emergency Medical Services, I should **DIAL 911** and request transportation to the hospital.

I acknowledge that I have been informed of known risks involved and hereby release the EMS providers, STAT Medical Transport, LLC, and the Medical Command Physician from all responsibility for any ill effects which may result from my refusal of evaluation, treatment, and/or transportation.

☐ Form read to patient.

Provider's Initials: _____

Patient Signature: _____ Date: _____

Provider's Signature: _____ Date: _____

Witness Signature: _____ Date: _____