

REMO RMA Check Sheet

PCR Number: ____ - ____

The REMO RMA check sheet is a guide to use while completing a Refusal of Medical Attention for any patient. This form is an adjunct to RMA documentation and is a continuation of the PCR. A copy of this RMA check sheet is to be attached to the PCR for every RMA.

CAPACITY of patient or guardian making the refusal:

- _____ Alert and oriented to person, place, time and events
- _____ Clear and coherent speech
- _____ No known or presumptive specific medical, legal or psychological conditions precluding competence
- _____ The patient is willing and able to engage in meaningful conversation
- _____ No evidence of alcohol or mind altering drug use

If any of the above are not checked, or the patient is less than 5 or greater than 65 years old, consider contacting medical control.

REMO Physician Number _____ Signal Number _____

PRECAUTIONS AND WARNINGS to patient:

- _____ Explained the potential known and unknown problems including, but not limited to:

- _____ Explained potential for fatal or permanently disabling consequences including, but not limited to:

- _____ Advised patient to seek care with an Emergency Department or physician as soon as possible.
- _____ Advised the patient to call 9-1-1 or their local EMS if their condition changes or they change their mind regarding care and transport.

Patient:

I, _____, understand that people maintain the right to refuse medical care, treatment and/or transportation. I further acknowledge that I have been advised by members of the _____ [Agency], that they recommend that I receive medical care, treatment and/or transportation to the hospital emergency department for further evaluation by a physician. I further understand that I may refuse medical care, treatment and/or transportation, but do so at my own risk. I do not have any known physical or mental condition that would prohibit me from making an informed decision to refuse the medical care, treatment and/or transportation that has been offered and recommended.

The risk associated with refusal may include possible loss of limb or life or permanent disability. I have also been advised that if I develop any medical complaints or symptoms I should immediately contact an ambulance, hospital emergency department or my physician.

I hereby release _____ [Agency], its officers, agents, personnel, and employees from any and all claims, causes of action or injuries, of whatsoever kind or nature, arising out of or in connection with my refusal of medical care, treatment and/or transportation.

Patient or Guardian _____ Date _____

Print name and relationship to patient if not same _____

Witness Name _____ Witness Signature _____

Provider Name _____ Provider Number _____

_____ This patient was given the information noted above and refused to sign the form as requested