

**SAMPLE EMERGENCY DEPARTMENT  
PATIENT TREATMENT OR TRANSFER  
CONSENT / REQUEST / REFUSAL**

**YOUR RIGHTS CONCERNING EMERGENCY CARE.**

- You have the right receive an appropriate medical screening examination within the capability of the Hospital to determine whether you have an emergency medical condition.
- If it is determined that an emergency medical condition exists, you have the right to receive treatment within the capability of the Hospital to stabilize the emergency medical condition or to receive an appropriate transfer to another medical facility to receive such treatment.
- You have the right to such emergency care even if you do not have insurance and cannot pay.

*Complete the box that applies.*

<input type="checkbox"/>	<p><b>CONSENT TO TRANSFER.</b> <i>[To be completed if the patient consents to a transfer recommended by a physician].</i></p> <p>I have been examined by a physician and/or by other qualified medical personnel. They have explained my condition to me, and have recommended that I be transferred to. The risks and benefits of the proposed transfer have been explained to me, and I understand that I have the right to emergency care as explained above. By signing below, I consent to the recommended transfer.</p>						
<input type="checkbox"/>	<p><b>REQUEST FOR TRANSFER.</b> <i>[To be completed if the patient requests a transfer that is not recommended by a physician].</i></p> <p>I have been examined by a physician and/or by other qualified medical personnel. They have explained my condition to me and have recommended that I <u>not</u> be discharged or transferred to another medical facility. They have explained the risks and benefits of the discharge or transfer. I am aware of the risks of discharge or transfer, and I understand that I have the right to emergency care as explained above. Nevertheless, by signing below, I request a transfer or discharge for the following reasons:</p> <p>1. Medical facility to which the patient requests a transfer: _____</p> <p>2. Patient's reason for requesting discharge or transfer: _____</p>						
<input type="checkbox"/>	<p><b>REFUSAL TO CONSENT TO TREATMENT OR TRANSFER.</b> <i>[To be completed if the patient refuses examination, treatment or transfer that is recommended by a physician].</i></p> <p>A physician and/or other qualified medical personnel have recommended that I receive the examination, treatment or transfer described below. The risks and benefits of the proposed treatment or transfer and the failure to receive the treatment or transfer have been explained to me. I understand that I have the right to emergency care as explained above. Nevertheless, by signing below, I refuse the proposed treatment or transfer for the following reasons:</p> <p>1. Examination, treatment, or transfer that was offered but refused: _____</p> <p>2. Patient's reason for refusing the examination, treatment or transfer: _____</p>						
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border-bottom: 1px solid black; padding-bottom: 5px;">Patient or authorized representative</td> <td style="width: 50%; border-bottom: 1px solid black; padding-bottom: 5px;">Date and time</td> </tr> <tr> <td style="border-bottom: 1px solid black; padding-bottom: 5px;">Relationship/authority of representative</td> <td></td> </tr> <tr> <td style="border-bottom: 1px solid black; padding-bottom: 5px;">Hospital witness</td> <td style="border-bottom: 1px solid black; padding-bottom: 5px;">Date and time</td> </tr> </table>		Patient or authorized representative	Date and time	Relationship/authority of representative		Hospital witness	Date and time
Patient or authorized representative	Date and time						
Relationship/authority of representative							
Hospital witness	Date and time						

*Note: if the patient or their representative refuses to sign the consent or refusal, complete the reverse side*

**PATIENT REFUSED TO SIGN CONSENT OR REFUSAL.** [To be completed by hospital if the patient refuses to sign a written consent or refusal].

The Hospital has taken all reasonable steps to obtain the patient's written informed consent or refusal for the examination, treatment or transfer described on the reverse side and/or in the medical records. The Hospital has explained to the patient or their representative the risks and benefits of the examination, treatment, or transfer, or the failure to obtain the examination, treatment or transfer. Despite the Hospital's efforts, the patient or their representative has refused to provide the written informed consent or refusal.

Explain the reason the patient refused to sign the consent or refusal, if known: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Hospital representative

\_\_\_\_\_  
Date

6183137\_v2

SAMPLE