HOLLAND&HART LLP

**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.*

❑ **CONSENT TO TRANSFER**. [*To be completed if the patient consents to a transfer recommended by a physician*].

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.

❑ **REQUEST FOR TRANSFER**. [*To be completed if the patient requests a transfer that is not recommended by a physician*].

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 not 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:

1. Medical facility to which the patient requests a transfer: _____
2. Patient's reason for requesting discharge or transfer: _____
_____

❑ **REFUSAL TO CONSENT TO TREATMENT OR TRANSFER**. [*To be completed if the patient refuses examination, treatment or transfer that is recommended by a physician*].

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:

1. Examination, treatment, or transfer that was offered but refused: _____
_____
2. Patient's reason for refusing the examination, treatment or transfer: _____
_____

_____ _____
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*




EMTALA consent_request_refusal form

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❑ **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






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