Facility:

NYC HEALTH+ HOSPITALS

Chart No.

Name

Unit

RETIRO EN CONTRA DEL CONSEJO MÉDICO / DEPARTURE AGAINST MEDICAL ADVICE

(Patient Imprint Card)

FORM D

Certifico que tengo más de 18 años de edad y que rechazo los servicios de este centro y me retiro en contra del consejo de los médicos de este centro. Reconozco que me han informado los riesgos, los efectos y los peligros para mi salud y posiblemente para mi vida que podrían desencadenarse a partir de mi decisión de retirarme del centro en este momento. Me han dado tiempo para hacer preguntas sobre mi afección y mi decisión de retirarme en contra del consejo médico.

Asumo los riesgos voluntariamente y acepto las consecuencias de mi decisión de retirarme de este centro y libero de responsabilidad a todos los proveedores de atención médica, al centro y a su personal por cualquier efecto perjudicial que podría ocasionar mi decisión de retirarme del centro. Tengo entendido que el centro no ha hecho ningún arreglo para transferirme a otro centro ni tampoco se ha confirmado mi ingreso en ningún otro centro.

	y/and		**a. m./am**
Firma del paciente mayor de edad / Signature of Adult Patient	**Fecha/Date**	**Hora/Time**	**p. m./pm**

If the patient cannot consent for themself, the signature of either the health care agent, legal guardian or surrogate who is acting on behalf of the patient must be obtained.

	y/and		**a. m./am**
Firma del representante de atención médica/el tutor legal/el sustituto / Signature of Health Care Agent/Legal Guardian /Surrogate	**Fecha/Date**	**Hora/Time**	**p. m./pm**

IMPORTANT:

In some circumstances, the surrogate may not refuse treatment on behalf of a patient who lacks decisional capacity. Similarly, a parent/legal guardian may not refuse some types of treatment on behalf of a minor patient. Vaccinations may be refused in certain circumstances. Refer to OP 180-06 for further instruction and/or contact the facility's Risk Manager.

WITNESS:

I, _____, am a staff member who is not the patient's physician or authorized health care provider and I have witnessed the patient, or an authorized representative, voluntarily sign this form.

I, _____, am a staff member who is not the patient's physician or authorized health care provider and I have witnessed that the patient is **unable** to sign this form ☐; **OR** that the patient or an authorized representative, **refused** to sign this form ☐ . **(Check one box.)**

	and		**am**
Signature and Title of Witness	**Date**	**Time**	**pm**

INTERPRETER: (To be signed by the interpreter if the patient required such assistance)
I have provided an accurate and complete interpretation of an explanation/discussion of this form between the health care provider(s) and the patient or the patient's authorized representative.

	and		**am**
Signature of Interpreter (if present), ID# and Agency Name	**Date**	**Time**	**pm**

Facility:

DEPARTURE AGAINST MEDICAL ADVICE PROGRESS NOTE

(The Departure Against Medical Advice Form HH 100D on the reverse side must also be completed)

Chart No.

Name

Unit

(Patient Imprint Card)

NYC HEALTH+ HOSPITALS

On _____ (Date and Time), the above-named patient decided to leave the facility against medical advice. I explained the risks and consequences and danger to the health and possibly life of the above-named patient.

As I explained to the patient, the risks, consequences and dangers of leaving the facility against medical advice include but are not limited to:

I provided the above-named patient with the opportunity to ask questions. I have answered the questions asked and it is my professional opinion that the patient understands what I have explained.

_____ _____ **and** _____ **am**

Signature of Attending Physician or Authorized Health Care Provider* **Date** **Time** **pm**

_____

Print Name and License Number

IF SOMEONE IS MAKING HEALTH CARE DECISIONS FOR THE PATIENT, THE ATTENDING PHYSICIAN MUST CERTIFY THAT THE PATIENT LACKS DECISIONAL CAPACITY.

ATTENDING PHYSICIAN'S CERTIFICATION

I have examined the above-named patient and it is my professional medical opinion that this patient lacks decisional capacity to make informed health care decisions. I understand that if this patient has appointed a health care agent to make these decisions, a copy of the patient's Health Care Proxy must be inserted in the medical record. If the patient's surrogate has refused the proposed treatment, the surrogate has signed the form.

_____ _____ **and** _____ **am**

Signature of the Attending Physician **Date** **Time** **pm**

_____

Print Name and License Number

_____

* Authorized Health Care Provider is one who is credentialed and privileged by the medical staff to perform this diagnostic test, procedure or surgery that requires informed consent.