Facility:

Chart No.

Name

Unit

*(Patient Imprint Card)*

NYC HEALTH+ HOSPITALS

# RECHAZO DEL PACIENTE AL TRATAMIENTO, PROCEDIMIENTO O VACUNA / PATIENT REFUSAL OF TREATMENT, PROCEDURE, OR VACCINATION

**FORM C**

Certifico que tengo más de 18 años de edad y que rechazo _____

_____ (Indique el tratamiento/procedimiento/vacuna / Identify treatment/procedure/vaccination). Entiendo que esta negativa es contraria al consejo de mis proveedores de atención médica. 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 rechazo de este tratamiento/procedimiento/vacuna.

También me han dado tiempo para hacer preguntas sobre mi afección y mi decisión de rechazar el tratamiento/procedimiento/vacuna, el cual está médicamente indicado y es necesario de acuerdo con lo que me explicó mi proveedor de atención médica.

Asumo los riesgos voluntariamente y acepto las consecuencias de mi negativa a recibir el tratamiento/procedimiento/vacuna 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 rechazo del tratamiento.

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

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

(Place a copy of the authorizing document in the medical record)

**IMPORTANTE:**

**En algunas circunstancias, el sustituto no podrá rechazar el tratamiento en nombre de un paciente que carezca de capacidad para tomar decisiones. De la misma forma, un padre/madre/tutor legal no podrá rechazar ciertos tipos de tratamientos en nombre de un paciente menor de edad. Es posible rechazar las vacunas en determinadas circunstancias. Consulte OP 180-06 para obtener más instrucciones o comuníquese con el gerente de riesgos del centro.**

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

Facility:

Chart No.

Name

Unit

*(Patient Imprint Card)*

NYC HEALTH+ HOSPITALS

# PATIENT REFUSAL OF TREATMENT, PROCEDURE, OR VACCINATION PROGRESS NOTE

**(The Refusal of Treatment Form HH 100C on the reverse side must also be completed)**

On _____ (Date), the above-named patient refused the treatment/procedure/vaccination which is medically indicated and necessary. I explained the risks, consequences and danger to the health and possibly thelife of the above-named patient.

As I explained to the patient, the risks, consequences and dangers of refusing the treatment, procedure, or vaccination include but are not limited to:

_____

_____

_____

_____

_____

_____

_____

**Vaccinations Refused**

- ☐ DPT/DTaP
- ☐ Hepatitis A/Hepatitis B
- ☐ HiB
- ☐ Influenza
- ☐ MMR
- ☐ Measles
- ☐ Meningococcus
- ☐ Mumps
- ☐ Pneumococcus
- ☐ Polio
- ☐ Rubella
- ☐ Td
- ☐ Varicella
- ☐ Other_____

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**

**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.**

**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.