Facility:

NYC HEALTH+ HOSPITALS

Chart No.

Name

Unit

(Patient Imprint Card)

DEPARTURE AGAINST MEDICAL ADVICE

FORM D

This is to certify that I am over the age of 18 and I am refusing the services of this facility and I am leaving this facility against the advice of the physicians at this facility. I acknowledge that I have been informed of the risks, consequences and the dangers to my health and possibly to my life which may result if I leave the facility at this time. I have been given time to ask questions about my condition and about my decision to leave against medical advice.

I voluntarily assume the risks and accept the consequences of my decision to leave this facility at this time and I am releasing all of the health care providers, the facility and its staff from any and all liability for ill effects that may result from my leaving this facility. I understand that no arrangements have been made by the facility to transfer me to another facility, nor has my admission to any other facility been confirmed.

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

Signature of Adult Patient **Date** **Time** **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.

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

Signature of Health Care Agent/Legal Guardian/Surrogate **Date** **Time** **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

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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.

Signature of Attending Physician or Authorized Health Care Provider*	**Date**	**Time** _____ **am** _____ **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.

Signature of the Attending Physician	**Date**	**Time** _____ **am** _____ **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.