Facility: **Kings County Hospital Center**

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc

# DEPARTURE AGAINST MEDICAL ADVICE

Chart No.

Name

Unit

*(Patient Imprint Card)*

## 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 him/herself, 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**
(Place a copy of the authorizing document in the medical record)

**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 OP180-06 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 other appropriate person voluntarily sign this form.

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

**INTERPRETER/TRANSLATOR:** (To be signed by the interpreter/translator if the patient required such assistance)

To the best of my knowledge the patient understood what was interpreted/translated and voluntarily signed this form.

_____ _____ **and** _____ **am**
**Signature of Interpreter/Translator** **Date** **Time** **pm**

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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 Identification 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 Identification 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. See also HHC Consent Policy, Article III.