Facility: **Kings County Hospital Center**

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

Chart No.

Name

Unit

(Patient Imprint Card)

REFI POU TRETMAN, PWOSEDI OSWA VAKSINASYON PASYAN AN BAY
(PATIENT REFUSAL OF TREATMENT, PROCEDURE OR VACCINATION)

FORM C

Mwen sètitfye ke mwen gen pliske 18 lane e map refize _____

_____ (Idantifye Pwosedi/Tretman/Vaksinasyon an/ **Identify Procedure/Treatment/Vaccination**). Mwen konprann refi sa a alankont de konsèy pwofesyonèl k ap bay swen sante yo banmwen. Mwen rekonèt ke yo te enfòme m sou risk, konsekans ak danje sou sante mwen e pwobableman sou lavi mwen ki ka rive poutèt mwen refize pwosedi/tretman/vaksinasyon sa a.

Yo te banm tan pou m te poze kesyon sou kondisyon m nan ak sou desizyon m nan pou refize pwosedi/tretman/vaksinasyon an ke pwofesyonèl k ap bay swen sante m nan te esplike m te yon bezwen medikal e ki nesesè.

Mwen volontèman pran responsabilite pou risk ki ka genyen yo e mwen aksepte konsekans ki ka genyen poutèt mwen refize pwosedi/ tretman/vaksinasyon an epitou mwen pap rann pwofesyonèl k ap bay swen sante yo, etablisman an ak manm pèsonèl li yo responsab pou okenn efè maladi ki ta ka rive akozde refi mwen bay pou m pa resevwa tretman an.

_____	_____	ak	_____	am
Siyati pasyan adilt la	**Dat**	**(and)**	**Lè**	**pm**
(Signature of Adult Patient)	**(Date)**		**(Time)**	

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.

_____	_____	ak	_____	am
Siyati reprezantan k ap pran desizyon sou swen sante a/ responsab legal la/ranplasman	**Dat**	**(and)**	**Lè**	**pm**
Signature of Health Care Agent/Legal Guardian/Surrogate	**(Date)**		**(Time)**	
(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 OP 180-06 for further instruction and/or contact the facility's Risk Manager.

TEMWEN (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.

_____	_____	ak	_____	am
Siyati ak tit temwen an (Signature and Title of Witness)	**Dat**	**(and)**	**Lè**	**pm**
	(Date)		**(Time)**	

ENTÈPRÈT/TRADIKTÈ (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.

_____	_____	ak	_____	am
Siyati entèprèt la/tradiktè a (Signature of Interpreter/Translator)	**Dat**	**(and)**	**Lè**	**pm**
	(Date)		**(Time)**	

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REFUSAL OF TREATMENT PROCEDURE OR VACCINATION PROGRESS NOTE

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

Chart No.

Name

Unit

(Patient Imprint Card)

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 the life of the above-named patient.

As I explained to the patient, the risks, consequences and dangers of refusing the procedure 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 Identification 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 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.