Facility: **Kings County Hospital Center**

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
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RECHAZO DE TRATAMIENTO, PROCEDIMIENTO O VACUNA POR PARTE DE UN PACIENTE
(PATIENT REFUSAL OF TREATMENT, PROCEDURE OR VACCINATION)

Chart No.

Name

Unit

(Patient Imprint Card)

FORM C

Por la presente certifico que soy mayor de 18 años de edad y rechazo el/la _____ _____ (Identificar procedimiento/tratamiento/vacuna / **Identify Procedure/Treatment/Vaccination**). Entiendo que mi negativa a recibirlo es contraria a la recomendación de los profesionales que me atienden. Declaro haber recibido información sobre los riesgos, consecuencias y peligros para mi salud y probablemente para mi vida que pueden presentarse como resultado de mi negativa a recibir este procedimiento/tratamiento/vacuna.

Se me ha dado tiempo para hacer preguntas sobre mi afección y sobre mi decisión de negarme a recibir el procedimiento/tratamiento/ vacuna que mi proveedor de atención médica considera que está médicamente indicado y es necesario.

Asumo voluntariamente los riesgos y acepto las consecuencias de mi decisión de rechazar el procedimiento/tratamiento/vacuna y libero de responsabilidad a todos los profesionales, a la institución y a todo su personal por cualquier responsabilidad y por las posibles consecuencias negativas de mi decisión.

_____	_____ y _____ am
Firma del paciente adulto (Signature of Adult Patient)	**Fecha (Date) (and) Hora (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.

_____	_____ y _____ am
Firma del agente de salud o tutor legal/representante Signature of Health Care Agent/Legal Guardian/Surrogate (Place a copy of the authorizing document in the medical record)	**Fecha (Date) (and) Hora (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.

TESTIGO (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.

_____	_____ y _____ am
Firma y cargo del testigo (Signature and Title of Witness)	**Fecha (Date) (and) Hora (Time) pm**

INTÉRPRETE/TRADUCTOR (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.

_____	_____ y _____ am
Firma del intérprete/traductor (Signature of Interpreter/Translator)	**Fecha (Date) (and) Hora (Time) pm**

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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.