

Facility:

Kings County Hospital Center

Chart No.

Name

Unit

(Patient Imprint Card)

PRAN DESIZYON ALANKONT KONSEY MEDIKAL (DEPARTURE AGAINST MEDICAL ADVICE)

FORM D

Sa a se pou sètifye ke mwen gen pliske 18 lane e ke m ap refize sèvis etablisman sa a epitou m ap soti nan etablisman sa a malgre konsèy doktè nan etablisman sa a mande pou m rete. Mwen rekonèt ke yo te enfòm m sou risk, konsekans ak danje sou sante mwen e pwobableman sou lavi mwen ki ka rive poutèt mwen soti nan etablisman sa a kounye a. Yo te banm tan pou m te poze kesyon sou kondisyon m nan ak sou desizyon m nan pou kite malgre konsèy medikal yo.

Mwen volontèman pran responsab pou risk ki ka genyen yo e mwen aksepte konsekans ki ka genyen poutèt mwen deside soti nan etablisman sa a kounye a epitou mwen pap rann pwofesyonèl k ap bay swen sante yo, etablisman an ak manm pèsone l li yo responsab pou okenn efè maladi ki ta ka rive akòz desizyon mwen pran an pou m kite etablisman sa a. Mwen konnen ke etablisman an pa fè okenn aranjman pou l transfere m nan yon lòt etablisman, ni nonplis tou yo pa konfime ke yo admèt mwen nan okenn lòt etablisman.

Siyati pasyan adilt la
(Signature of Adult Patient)

Dat
(Date)

ak
(and)

Lè
(Time)

am
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.

Siyati reprezantan k ap pran desizyon sou swen sante a/
responsab legal la/ranplasan
Signature of Health Care Agent/Legal Guardian/Surrogate
(Place a copy of the authorizing document in the medical record)

Dat
(Date)

ak
(and)

Lè
(Time)

am
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.

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.

Siyati ak tit temwen an (Signature and Title of Witness)

Dat
(Date)

ak
(and)

Lè
(Time)

am
pm

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.

Siyati entèprèt la/tradiktè a (Signature of Interpreter/Translator)

Dat
(Date)

ak
(and)

Lè
(Time)

am
pm

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**DEPARTURE AGAINST
MEDICAL ADVICE**

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 and _____
Time am
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.

Signature of the Attending Physician

Date and _____
Time am
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.