NEW YORK CITY
HEALTH AND HOSPITALS CORPORATION

ABANDONO DEL CENTRO DE SALUD EN CONTRA DE LOS CONSEJOS MÉDICOS
(DEPARTURE AGAINST MEDICAL ADVICE)

Chart No.

Name

Ward No.

(Patient Imprint Card)

FORM D

Por el presente certifico que soy mayor de 18 años y que no autorizo los servicios de este establecimiento. Asimismo, abandono este centro asistencial en contra de los consejos de sus médicos. Certifico que he sido informado acerca de los riesgos, consecuencias y peligros para mi salud e incluso mi vida que supone abandonar el establecimiento en este momento. He tenido tiempo para realizar preguntas sobre mi condición y decisión de retirarme en contra de los consejos de los médicos.

Asumo por propia voluntad los riesgos y acepto las consecuencias que implica abandonar el establecimiento en este momento. Asimismo, libero a todos los prestadores de servicios médicos, al establecimiento y a su personal de toda responsabilidad por los efectos perjudiciales que pudieran surgir de mi decisión. Entiendo que este establecimiento no ha dispuesto mi traslado ni que existe confirmación alguna de que otro establecimiento me haya admitido.

Firma del paciente mayor de edad
(Signature of Adult Patient)

Fecha
(Date)

If the patient cannot consent for him/herself, the signature of either the health care agent or legal guardian who is acting on behalf of the patient must be obtained.

Firma del agente de salud o tutor legal
(Signature of Health Care Agent/Legal Guardian)

Fecha
(Date)

IMPORTANT:

The patient's next of kin may not refuse medically necessary treatment on behalf of a patient who lacks decisional capacity. Similarly, a parent/legal guardian may not refuse medically necessary treatment on behalf of a minor patient. Refer to the HHC Consent Policy for further instruction and contact the facility's Risk Manager.

TESTIGO (WITNESS):

I, _____ am a facility employee who is not the patient's health care provider and I have witnessed the patient or other appropriate person voluntarily sign this form.

Firma y cargo del testigo (Signature and Title of Witness)

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.

Firma del intérprete o traductor (Signature of Interpreter/Translator)

FOR FACILITY USE ONLY

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DEPARTURE AGAINST MEDICAL ADVICE

Chart No.

Name

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(Patient Imprint Card)

On _____ (Date), 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**

_____

Print Name and Identification Number

IF SOMEONE IS MAKING HEALTH CARE DECISIONS FOR THE PATIENT BASED ON A HEALTH CARE PROXY, 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.

_____ _____

Signature of the Attending Physician **Date**

_____

Print Name and Identification Number