Facility: **Elmhurst Hospital Center**

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

Chart No.

Name

Unit

(Patient Imprint Card)

ALTA VOLUNTARIA EN CONTRA DE LA INDICACIÓN MÉDICA
(DEPARTURE AGAINST MEDICAL ADVICE)

FORM D

Por la presente certifico que soy mayor de 18 años de edad y me niego a recibir los servicios de esta institución y que me retiro desatendiendo las recomendaciones de los médicos de la institución. 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 decisión de retirarme de la institución en este momento. He tenido tiempo de hacer preguntas sobre mi afección y sobre mi decisión de retirarme desatendiendo las recomendaciones médicas.

Asumo voluntariamente los riesgos y acepto las consecuencias de mi decisión de retirarme de la institución en este momento y libero a todos los profesionales, a la institución y a todo su personal de cualquier responsabilidad y de las posibles consecuencias negativas de mi decisión. Entiendo que la institución no ha dispuesto transferirme a otro centro ni se ha confirmado mi admisión a otra institución.

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

_____	_____ 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 (and) Hora pm** **(Date) (Time)**

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 (and) Hora pm** **(Date) (Time)**

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 (and) Hora pm** **(Date) (Time)**

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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.

_____ _____**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.