Facility: **North Central Bronx Hospital**

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

PATIENT REFUSAL OF TREATMENT, PROCEDURE OR VACCINATION

Chart No.

Name

Unit

(Patient Imprint Card)

FORM C

This is to certify that I am over the age of 18 years and I am refusing the _____

_____ (Identify Procedure/Treatment/Vaccination). I understand this refusal is against the advice of my health care providers. I acknowledge that I have been informed of the risks, consequences and the danger to my health and possibly to my life which may result from my refusal of this procedure/treatment/vaccination.

I have been given time to ask questions about my condition and about my decision to refuse the procedure/treatment/vaccination which my health care provider has explained to me is medically indicated and necessary.

I voluntarily assume the risks and accept the consequences of my refusal of the procedure/treatment/vaccination and I am releasing all of the health care providers, the facility and its staff from any and all liability for all ill effects that may result from my refusal of treatment.

_____	_____ and _____ am
Signature of Adult Patient	**Date** **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.

_____	_____ and _____ am
Signature of Health Care Agent/Legal Guardian/Surrogate (Place a copy of the authorizing document in the medical record)	**Date** **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 OP180-06 for further instruction and/or contact the facility's Risk Manager.

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.

_____	_____ and _____ am
Signature and Title of Witness	**Date** **Time** pm

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.

_____	_____ and _____ am
Signature of Interpreter/Translator	**Date** **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)

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.