

SECTION – MEDICAL/NURSING SERVICES
ADMINISTRATIVE DIRECTIVE NO. 598
(Replaces A.D. No. 598 dated 8/10/06)

Effective Date: July 12, 2007

SUBJECT: REFUSAL OF SERVICES

I. PURPOSE

To ensure good documentations of refusal to undergo recommended medical diagnostic and/or therapeutic procedures.

II. AUTHORITY

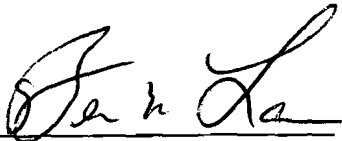
California Code of Regulations, Title 22, Section 73524 (a).

III. POLICY

It is the policy of Coalinga State Hospital (CSH) that when an Individual refuses a recommended diagnostic or therapeutic procedure/consultation the Individual should be counseled about this and a "Patient Refusal of Treatment" form (CSH 098) must be filled out and signed. All Individuals are considered competent to refuse medical treatment unless adjudicated to be in need of a conservator (See A.D. No. 546).

IV. METHOD

- A. If an Individual refuses a recommended therapeutic procedure/consultation, staff shall ask them the reasons for this. If the problem can be rectified, staff will do so. This should be done as soon as possible, preferably by the internist recommending the procedure/consultation.
- B. If the Individual still refuses, staff will counsel the Individual about the risks of not having the procedure or consultation.
- C. If the Individual still refuses, the Individual shall sign the "Patient Refusal of Treatment" form with a staff signing as witness. If the Individual refuses to sign, then staff will document this on the form and in an Interdisciplinary Note (IDN) or a Physician's Progress Note (PPN).
- D. All Individuals are considered competent to refuse a medical procedure/treatment. A treatment team meeting shall be held within 72 hours of such a refusal. The team may choose to evaluate whether the Individual is competent to refuse medical treatment. If they do not think so, the conservatorship process should be initiated (See A.D. No. 546).



BEN MCLAIN
Executive Director (Acting)

Cross Reference(s):

A.D. No. 546 Procedure for Authorizing Involuntary Medical Treatment

Attachment – CSH 098 Patient Refusal of Treatment

The following examinations or procedures have been ordered for you by your physician, Dr. _____ and were discussed with you on _____.

IF YOU CHOOSE TO DECLINE PLEASE STATE YOUR REASON FOR REFUSING AND READ, SIGN AND DATE BELOW.

I have been informed of the risks and possible consequences involved in refusal of the physician ordered examination and/or procedure. **I refuse to accept such examination or procedure.** I agree to hold Coalinga State Hospital and its staff free of any responsibility for any injury or complications that may result from my refusal.

Patient's Signature

Date

Witness' Signature

Date

Witness' Signature

Date

Patient Refusal of Treatment

Addressograph

Confidential Client Information
See W & I Code Section 5328

File under Consents Tab