Refusal of Treatment

Patient Name	*Patient Number*	*Booking Number*	*Date of Birth*	*Today's Date*

I, _____ have, this day, knowing that I have a condition requiring
(Name of Patient)

medical care as indicated below:

_____ A. Refused medication
_____ B. Refused dental care
_____ C. Refused an outside medical appointment
_____ D. Refused laboratory services
_____ E. Refused X-Ray service
_____ F. Refused other diagnosis services
_____ G. Refused physical exam
_____ H. Other (Please specify)

_____

_____

Reason for Refusal _____

_____

_____

Potential Consequences Explained:

_____A. Worsening Of Medical Conditions
_____B. Death
_____C. Permanent Disability
_____D. Other _____

I acknowledge that I have been fully informed of and understand the above refused treatment and the risks involved in refusing. I hereby release and agree to hold harmless CCS and correctional personnel from all responsibility and any ill effects which may result from this refusal.

I have read this form and certify that I understand its contents.

_____
Witness Signature

_____
Witness Signature

_____
Patient Signature

_____
Date

_____
Time

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CCS-CT02 (formerly CCS-009)
revised 04.16.2012

Rechazo del Tratamiento
Refusal of Treatment

Patient Name	*Patient Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Yo, _____ -en esta fecha- sabiendo que
(Nombre del paciente)
tengo una enfermedad que requiere tratamiento médico procedo de la siguiente forma:

___ A. Rechacé medicamentos - Refused Medication
___ B. Rechacé asistencia odontológica - Refused dental exam
___ C. Rechacé una consulta con un médico externo – Refused an outside medical appt
___ D. Rechacé someterme a análisis de laboratorio – Refused laboratory services
___ E. Rechacé estudios de radiografías – Refused X-Ray service
___ F. Rechacé otras formas de determinar mi diagnóstico – Refused other diagnostic service
___ G. Rechacé realizarme un examen físico – Refused physical exam
___ H. Otros (Por favor, indíquelos) – Other (please specify)

_____

_____

Motivos de mi rechazo (Reason for Refusal):_____

_____

_____

_____

Consecuencias futuras que se explicaron (Potential Consequences Explained):

_____ A. Empeoramiento de las condiciones médicas - Worsening of medical condition
_____ B. Muerte - Death
_____ C. Discapacidad permanente – Permanent Disability
_____ D. Otras – Other _____

Reconozco que se me informó plenamente sobre los tratamientos que rechacé anteriormente y sobre los riesgos que ello implica y que entiendo al respecto. Por medio del presente eximo de toda responsabilidad a CCS y al personal correccional que pueda derivar de los efectos de la enfermedad como consecuencia de mi rechazo.

Leí el presente formulario y certifico que comprendo su contenido.

_____
Witness signature

_____ _____
Witness signature Firma del paciente

_____ _____
Fecha (Date) Hora (Time)

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Vermont Work Camp
Health Service Reception Sheet

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

S: INMATE C/0s ON ARRIVAL _____

O: T_____P_____R_____ BP_____ WT_____ PPD_____H&P_____
ALLERGIES_____ OTHER EXAMINATION_____
_____
MEDICATIONS: _____
_____

A: _____

P: TRANSFER FORM REVIEWED: Y/N
MEDICAL ACCESS PROCEDURE REVIEWED: Y/N
GRIEVANCE PROCEDURE REVIEWED: Y/N
BLOOD-BORNE PATHOGEN INFO REVIEWED: Y/N
SEXUAL ASSAULT AWARENESS HANDOUT GIVEN: Y/N

REFERRALS:

a. EMERGENCY ROOM Y/N
b. HCP Y/N _____
c. CHRONIC ILLNESS CLINIC Y/N _____
d. DENTAL Y/N (IF NO, REFUSAL SIGNED) Y/N EDUCATION PROVIDED Y/N
e. MENTAL HEALTH REFERRAL Y / N _____
f. DIET Y/N BOTTOM BUNK PASS Y/N

OTHER ACTIONS TAKEN_____
_____
_____

SIGNATURE_____ DATE□□□□□□□□□□□□□□□□□□□□□□□/

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Vermont 2013