FORM 9-1

Patient Refusal of Transfer

I acknowledge that I have been offered a transfer to another medical facility for medical treatment and that I refuse this transfer. I have been informed of the risks and consequences potentially involved in this refusal, the possible benefits of transfer to another medical facility, and any alternatives to my decision to refuse the transfer.

I refuse this transfer because _____

_____

_____

I hereby release the attending physician, any other physicians involved in my care, the hospital, and its agents and employees, from all responsibility for any ill effects which may result from my refusal of further medical examination and treatment.

I understand that the physicians involved in my care are not employees or agents of the hospital. They are independent medical practitioners.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

COPY MUST BE GIVEN TO PATIENT.

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

Reference: 42 U.S.C. Section 1395dd(b)(2)

FORM 9-1S

Rechazo de Traslado de Parte del Paciente

Reconozco que se me ha ofrecido ser trasladado a otra institución médica para recibir tratamiento médico y que yo rechazo dicho traslado. Se me ha informado acerca de los riesgos y consecuencias que pueden estar implícitas en este rechazo, de los posibles beneficios de ser trasladado a otra institución médica y de cualquier alternativa a mi decisión de rechazar dicho traslado.

Yo rechazo dicho traslado porque _____

_____

_____

Por medio de la presente exonero al médico de mi caso, a cualquier otro médico involucrado en mi atención médica al hospital y a sus agentes y empleados, de toda responsabilidad por cualquier efecto adverso que pueda resultar de mi rechazo de un exámen y tratamiento médico adicional.

Entiendo que el médico que me atiende y otros médicos que me brindan servicios no son empleados ni agentes del hospital. Son médicos facultativos independientes.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente o representante legal)

Si no lo firma el paciente, indique la relación con éste: _____

Nombre en letra de imprenta: _____
(representante legal)

COPY MUST BE GIVEN TO PATIENT.

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

Reference: 42 U.S.C. Section 1395dd(b)(2)