OREGON DEPARTMENT OF CORRECTIONS
Operations Division
Health Services Section Policy and Procedure #P-I-06

SUBJECT: RIGHT TO REFUSE TREATMENT

POLICY: Inmates may elect to refuse specifically recommended or prescribed health care procedures.

Inmates must be provided with sufficient information by health care professionals to make an informed decision if the inmate elects to refuse recommended health care and/or treatment. Any refusal of health care and/or treatment shall be written and placed in the health care record.

Health care professionals shall periodically discuss the recommended treatment or care with an inmate whose refusal has significant adverse health risks or consequences.

REFERENCE: OAR 291-124-080(2)
NCCHC Standard P-I-06

PROCEDURE:

A. An inmate who elects to refuse a specific aspect of recommended health care or treatment shall be provided with an explanation of the health risks or consequences of the refusal by the health professional. Refusing treatment at a particular time does not waive the patient's right to subsequent health care.

B. At the time of the inmate's stated refusal, complete the treatment refusal form (attached).

C. Provide the completed form to the inmate to sign and date in the presence of a health services witness.

D. In the presence of the inmate, the witness is to sign and date the treatment refusal form.

E. If the inmate refuses to sign the form, the witnessing health services staff is to sign and date the form indicating the inmate's refusal to sign.

F. The health professional will document the information provided, circumstances, and the inmate's stated reason for refusal in the progress notes of the health care record.

G. The completed treatment refusal form is then filed in the health care record in the Consents section.

H. Forward the health care record to the Chief Medical Officer, or designee, for clinical review, if appropriate.

I. The Chief Medical Officer, or designee, will review the circumstances and clinical consequences of the inmate's treatment refusal. If the refusal presents significant adverse health risks, schedule the patient for a subsequent appointment with the provider to discuss the refusal. A corresponding progress note will be written in the health care record. If adverse health risks are expected, the refusal is to be noted on the health care record problem list.

J. An inmate may rescind a treatment refusal at any time by notifying Health Services and consenting to recommended health care and/or treatment. Enter the inmate's stated decision to rescind treatment refusal and circumstances into the progress notes. If the treatment is identified on the problem list, note the date of rescinding refusal in the resolved column.

K. If the inmate is rescinding refusal for health care and/or treatment that is significant, initiate the procedure to obtain written informed consent.

L. If an inmate refuses health care and/or treatment that place others in the institution at risk of infectious disease, the inmate is to be appropriately isolated as per P&P #P-B-01.1, Isolation Control Precautions.

Effective Date: _____
Revision date: November 2006
Supersedes P&P dated: April 2005

Oregon Department of Corrections

IMPORTANT

Sign only in one place after carefully reading entire form.

PATIENT INFORMED CONSENT / REFUSAL

On_____, _____ has explained to me in a way
(Date) (Name of provider)
that I understand:

1. The general treatment or procedure to be undertaken:_____
_____
_____

2. There may be other procedures or methods of treatment; and

3. There are risks to the procedure or treatment proposed.

My provider has also asked if I want a more detailed explanation; but I am satisfied with the explanation and do not want any more information. I give my permission and consent to the treatment or procedure.

_____ X_____
(DATE) (PATIENT'S SIGNATURE)

SIGN IN THIS BOX ONLY IF YOU REQUESTED AND RECEIVED MORE DETAILED INFORMATION

After explanation of the procedure or treatment, other alternative procedures or methods of treatment and information about the material risks of the procedure or treatment, **I give my permission and consent** to the procedure or treatment.

_____ X_____
(DATE) (PATIENT'S SIGNATURE)

SIGN IN THIS BOX ONLY IF YOU REFUSE THIS TREATMENT OR PROCEDURE

After explanation of the procedure or treatment, other alternative procedures or methods of treatment and information about the material risks of the procedure or treatment, **I do NOT give permission and consent** to the procedure or treatment.

_____ X_____
(DATE) (PATIENT'S SIGNATURE)

Explained by me and signed in my presence:

_____ _____
(PROVIDER) (DATE)

_____ _____
(WITNESS) (DATE)

Name:_____
SID#:_____
DOB:_____