COUNTY OF LOS ANGELES **DEPARTMENT OF HEALTH SERVICES**

HARBOR-UCLA MEDICAL CENTER

SUBJECT: MEDICAL TREATMENT AND INFORMED CONSENT **POLICY NO. 604A**

PURPOSE:
To ensure that every competent adult has the fundamental right of self-determination over his or her body and property. Individuals who are unable to exercise this right, such as minors and incompetent adults, have the right to be represented by another who will protect their interests and preserve their basic rights.

A patient's right to decide whether or not to submit to medical treatment establishes the practitioner's corresponding duty to inform the patient about the recommended care so that the patient's decision is meaningful. The practitioner's duty of disclosure arises from the fiduciary quality of the practitioner-patient relationship, which is based upon the patient's dependence on the practitioner's specialized knowledge (*Cobbs v. Grant*, 8 Cal. 3D 242 (1972). In order to give informed consent, the patient must be informed of the nature of the treatment/procedure; the risks, complications and expected benefits or effects of the procedure; any alternatives to the treatment and their risks and benefits; and any potentially conflicting interest the practitioner may have (such as research or financial interests).

DEFINITION:
Practitioner: Defined as any ***physician, dentist, or health-care professional (Certified Registered Nurse Anesthetist, Certified Nurse Midwife, Registered Nurse Practitioner, Physician Assistant)*** who has been granted specific clinical privileges, or Registered Nurses and Physician Assistants who function under standardized procedures to perform the treatment or procedure involved. For the purpose of obtaining informed consent for medical treatment, the term practitioner includes medical and dental residents regardless of whether they have been granted clinical privileges.

POLICY:
Harbor-UCLA treating practitioners have both a legal and ethical duty to obtain the patient's consent, or the consent of the patient's legal representative, to medical treatment. If a patient refuses to consent to a proposed treatment, the practitioner must ensure that the patient is aware of the possible risks and complications that may occur as a result of such refusal.

EFFECTIVE DATE: 3/80 **SUPERSEDES:**
REVISED: 12/82, 10/86, 3/96, 9/98, 10/98, 10/99, 1/04, 2/05, 4/05, 8/06, 4/07, 5/08, 1/12, 1/14, 12/14, 10/16, 1/17, 7/17, 4/18, 5/19, 11/19, 2/20
REVIEWED: 12/82, 10/86, 9/89, 10/92, 3/96, 9/98, 10/98, 1/12, 1/14, 12/14, 10/16, 1/17, 7/17, 4/18, 5/19, 11/19, 2/20
REVIEWED COMMITTEE: Medical-Legal Committee

APPROVED BY:

Kim McKenzie, RN, MSN, CPHQ
Chief Executive Officer

Anish Mahajan, MD
Chief Medical Officer

Nancy Blake, PhD, RN, NEA-BC, FAAN
Chief Nursing Officer

The patient's "informed" consent, as distinguished from consent, is not required for all medical treatments. Informed consent is not required for the performance of "simple and common" procedures when the related risks are commonly understood such as blood drawing, IV placement and chest x-rays. However, the practitioner has the duty to inform the patient of the risks of refusing to undergo a simple and common procedure that has been recommended. The determination of which procedures are "complex" and, therefore, require informed consent is made by the medical staff (see **Appendix A**).

In the case of a medical emergency, indicated diagnostic and therapeutic interventions may be pursued without the patient's consent provided there is no evidence that the patient or the patient's legal representative would refuse such interventions. A medical emergency exists when immediate interventions are required for the alleviation of severe pain or for the immediate diagnosis and/or treatment of medical conditions that could lead to serious disability or death if not immediately addressed [Business and Professions Code section 2397 (c) (2), (3)]. In such cases, the emergency exception rule can and should be invoked. This rule does not require two physician signatures. However, in such instances, precise documentation in the medical record of the rationale for performance of the emergency interventions is required. Diagnostic or therapeutic interventions exceeding that needed for effective management of the emergent condition may not be performed without patient consent.

There are two special circumstances in which a practitioner is not required to obtain full informed consent:

- A practitioner need not disclose the risks of a recommended treatment when the patient has requested that s/he not be so informed.
- A practitioner is not required to disclose information to the patient if such disclosure would seriously harm, rather than benefit, the patient. (This is known as "Therapeutic Privilege").

Note: Neither exception should be relied upon by the practitioner unless it is clear that the facts and circumstances of the case justify invoking it and there is appropriate documentation. Reliance upon the "Therapeutic Privilege" should only be on rare occasions.

It is recommended that the practitioner carefully document in the patient's medical record that a discussion was held with the patient or the patient's legal representative and that informed consent was obtained or refused. The practitioner should indicate that s/he discussed the nature and benefits of the procedure, the risks and side effects associated with it; any alternatives to the procedure including their risks, benefits, and side effects; the risk associated with not performing the procedure; and any potentially conflicting interest the practitioner may have (such as research or financial interests).

Informed consent may be considered to have continuing force and effect unless the patient revokes the consent verbally. in writing, or until circumstances change so as to materially affect the nature of, or risks of the procedure and/or the alternatives to the procedure to which the patient consented.

PROCEDURE:

I. DETERMINING WHO HAS CAPACITY TO CONSENT

For the purpose of consenting to medical treatment, the person consenting must be an adult who has capacity.

- **Adult**: A person who has reached the age of 18 or a minor who has entered into a valid marriage, one who is on active duty with the armed forces of the United States, or who has been declared emancipated pursuant to Family Code Section 7122 et seq.

- **Capacity**: Defined as the ability to understand the nature and consequences of that, to which one is asked to consent.

Note: There are additional categories of minors who can give an informed consent in certain circumstances (see **Appendix B** and Consent Manual and Family Code Section 6922 et seq).

If the patient is unable to consent for him/herself and has not appointed a surrogate decision maker through a written or oral directive and there is no court appointed conservator, the patient's physician may, after a good faith inquiry, identify an individual to make health care decisions on behalf of the patient. The surrogate may or may not be a family member, but will be the individual who is best able to function in this capacity.

In determining the individual best able to represent the patient, all relevant factors may be considered, among them:

- Familiarity with the patient's personal values;
- Demonstrated care and concern for the patient;
- Degree of regular contact with the patient before and during the patient's illness;
- Availability to visit the patient;
- Availability to engage in meaningful contact with health care professionals for the purpose of fully participating in the health care decision making process;
- Ability to understand the medical condition and treatment options as explained by physicians or other health care professionals;
- Ability to assume the duties of a surrogate - to make health care decisions and advocate on behalf of the patient, and
- Previous designation as a surrogate, whose authority has expired.

Note: Agreement by a potential surrogate with the treatment recommendation of the physician or other healthcare professionals should not be the criteria used in the selection of a surrogate.

The patient's physician should document in the medical record who was selected as the surrogate decision maker and the basis for the surrogate selection. In difficult cases, the patient's physician is encouraged to contact the Office of Risk Management.

If the patient is judged to lack capacity to make medical decisions, a surrogate decision maker cannot be identified, an advance directive is not available or does not address specifically the issue at hand and/or, the medical decision is not an emergency, the process for medical decisions for such a patient will be initiated (See Section V).

II. OBTAINING INFORMED CONSENT

The process of informed consent shall involve (1) a discussion between an appropriate practitioner and the patient or surrogate regarding the nature of the treatment/procedure; the risks, complications and expected benefits or effects of the procedure; any alternatives to the treatment and their risks and benefits; and any potentially conflicting interest the practitioner may have (such as research or financial interests); and (2) appropriate signage of the informed consent form.

A. Who:

The discussion of the treatment/procedure will be held by a practitioner who routinely performs the procedure and is familiar with its risks, complications, and benefits. Except in cases of a life-threatening emergency, this discussion will be documented by the practitioner in the medical record prior to the planned procedure. Once the discussion has occurred, then signage of the informed consent form may be carried out by any practitioner.

- Peripherally Inserted Central Venous Catheter (PICC) placement consent can be obtained by the Vascular Access Team nurses.

B. How:

The practitioner may use verbal discussion, written information, audio or visual media to impart the information to the patient. In the case of certain procedures, State law may require the practitioner to give specific pamphlets or literature to the patient as part of the informed consent process. It is recommended that the practitioner give an explanation of the:

- Procedure or treatment;
- Name of the practitioner(s) who will be performing the task(s) – patients may be told that a resident may be performing significant tasks under the supervision of the attending;
  - Peripherally Inserted Central Venous Catheter (PICC) consent process and insertion can be done by Vascular Access Team nurses with a provider order for PICC placement/insertion;
  - In case of an emergency, or if the patient is unable to consent for him/herself and has not appointed a surrogate decision maker through a written or oral directive and there is no court appointed conservator, the Vascular Access Team must contact patient's provider to obtain consent for the PICC line placement procedure.
- Potential benefits including likelihood of success;
- Possible complications, risks or side effects including potential problems during recuperation;
- When indicated, possibility of urgent need for additional procedures;
- Alternatives and their risks, benefits and side effects;
- Possible results of not receiving care;
- When indicated, any limits on the confidentiality of information learned from or about the patient (usually related to research); and
- When indicated, any potentially conflicting interest (such as research or financial interests) the practitioner may have;

Such verbal discussion gives the patient the opportunity to ask questions about the information presented. Following this discussion, the practitioner obtains the patient's consent.

If a patient indicates that s/he intends to decline any medical treatment, the practitioner has a duty to advise the patient of all material risks that a reasonable person would want to be informed of before deciding not to undergo the test or treatment.

If a patient or his/her legal representative cannot communicate with the practitioner because of language or communication barriers, the practitioner (with the hospital's assistance) should arrange for an interpreter. The interpreter's responsibilities will include translating 1) the information regarding the recommended medical treatment that the patient or the patient's legal representative needs to receive before deciding whether to give consent, and 2) instructions regarding medical care.

III. DOCUMENTATION

A. Practitioner's Documentation:

When the patient or patient's representative authorizes complex medical treatment, or refuses recommended care, the practitioner **will**:

a. Document the consent or refusal of the patient or patient's representative by entering in the practitioner's progress note. This documentation will occur proximate to the time of the informed consent discussion with the patient or patient's representative.
b. Place in the medical record a copy of any written material provided to the patient/ representative;
c. Note the date and time of the discussion as well as a general summary of the content of the information discussed including the nature and benefits of the procedure, the risks associated with it and any other alternatives to the procedure including their risks and benefits. If any potentially conflicting interests were discussed, these should be included in the practitioner's note.

In the event the patient or patient's representative refuses the recommended medical treatment or procedure, the information provided regarding the risks of refusal should be documented in the practitioner's progress note and may also document time spent with patient or surrogate in discussion.

B. Consent Form:

Procedures requiring a consent form signed by the patient or patient's representative will be those complex treatments or invasive procedures that have an inherent medical risk as determined by the medical staff.

No abbreviations should be used on the consent form whether or not they are on the hospital's approved list of abbreviations. This includes such common notations as **"L"** for left and **"R"** for right. Lay terminology should be used to designate individual fingers, (i.e., thumb, index, middle, ring, and small fingers; similarly, toes should be designated as first through fifth toes).

Consent forms also must be signed by the practitioner obtaining the consent form, and an interpreter, when used. The signing practitioner will record the date and time of their signature on the form. When a person other than the patient signs a form, the relationship to the patient should be noted below the signature.

The hospital will maintain such forms in Spanish (**Appendix C - Spanish**) for use by patients whose preferred language is Spanish. English forms may be used for other non-English speaking patients with clear documentation that the discussion for obtaining the consent was carried out in the patient's language. If the practitioner speaks to the non-English speaking patient in the patient's language without an interpreter present, the practitioner should document this on the consent form.

When the patient or the patient's representative signs a consent form, that action does not remove the treating practitioner's duty to document the informed consent process in the progress notes.

In the event that the recommended procedure changes or a new informed consent is required because there are changes in the likelihood of the associated risks or benefits, documentation should clearly reflect the date and time of the new consent, including use of a new consent form.

If the person required to sign a consent form is unable to write his/her name, the person's mark must be obtained. This is done first by the hospital representative first writing the person's name in full and then having the person place an "X" beneath it. Two people must witness the signer place his/her mark on the consent form, and then must sign the form as witnesses.

C. Exceptions:
When an exception to the requirement of obtaining full informed consent exists as described above, the practitioner must clearly document the facts and circumstances justifying that determination.

IV. PROCEDURES AND TREATMENTS WITH INHERENT MEDICAL RISK

The Informed Consent Policy states that a consent form signed by the patient or patient's representative is required for all treatments and procedures with inherent medical risk or as required by law.

The medical staff has determined that treatments and procedures with inherent medical risks include all invasive procedures and those other treatments that have potential significant complications.

- Examples of treatments or procedures with inherent medical risk include blood transfusion, central line insertion, arterial line insertion, interventional radiologic procedures, and any procedure requiring moderate procedural sedation or anesthesia except for local anesthesia.
- Examples of simple and common procedures or treatments for which informed consent is not necessary include routine venipuncture, starting an intravenous infusion, insertion of a Foley catheter, physical therapy, and routine nursing care such as bathing or turning.

V. CONSENT FOR NON-EMERGENT TREATMENTS IN PATIENTS WITHOUT CAPACITY AND WITHOUT A SURROGATE

According to California Probate Code Section 4650(c), "In the absence of controversy, a court is normally not the proper forum in which to make health care decisions, including decisions regarding life-sustaining treatment." Thus, in accord with this statutory declarative, and as recommended by the California Hospital Association Manual of Consent, Harbor-UCLA Medical Center will use a multi-disciplinary approach to serve as a surrogate decision maker for certain medical decisions for patients who lack capacity and have no surrogate decision maker or applicable advance directive available ("unrepresented patient").

A. Multi-Disciplinary Committee
Consideration of a decision by a multi-disciplinary committee may be requested by the primary team attending physician. The request should be made to Risk Management who will determine if the request being made is appropriate for adjudication by the multi-disciplinary committee.

In general, an appropriate situation for convening a multi-disciplinary committee would include:

1. A patient who lacks capacity to make an informed decision about the proposed course of action;
2. Where a psychiatrist has participated in the determination of lack of capacity;
3. Where the health care decision is non-emergent; and
4. Where diligent efforts have been made over time to identify a surrogate decision maker without success, and these efforts have been documented in the medical record.

The Risk Manager, along with the Chief Medical Officer or their designee, will convene a multi-disciplinary committee.
The voting members of the committee will be comprised of:

1. The patient's primary attending physician (the attending physician must be present). Residents/fellows cannot serve or vote in place of the attending, but are encouraged to be present to provide background information.
2. A nurse from the patient's care team, who should be identified by name by the primary team.
3. A member of the Ethics Committee including, if possible, the Chair or Vice-Chair.
4. Consulting attending physicians, especially if appropriate to the decision to be made.
5. A social worker who is familiar with the patient and has participated in the care team.
6. A non-medical community member of the Ethics Committee or a representative from the patient advocacy/relations office.
7. A psychiatrist, when needed to determine lack of capacity, preferably one who participated in the determination of lack of capacity.
8. Risk Manager or designee (non-voting).

B. Decision-Making by the Multi-Disciplinary Committee
The multi-disciplinary team will review the patient's diagnoses and prognosis and determine goals of care by considering:

- Any known prior patient wishes
- Prioritizing relief of suffering or pain
- Preservation or improvement of function
- Quality of life and prognosis
- Degree of intrusiveness and invasiveness and discomfort of the procedure and future care needs
- Ethical principles involved, if any
- The specific course of action proposed by the patient's physicians and its intended goals.

Agreement on Treatment:

a. If all members of the multi-disciplinary team agree to the appropriateness of providing treatment, it will be provided.
b. If all members of the multi-disciplinary team agree to the appropriateness of withholding or withdrawing treatment, it shall be withdrawn or withheld. Any implementation of a decision to withhold or withdraw life sustaining medical treatment will be the responsibility of the attending physician.

Disagreement on Treatment:
If members of the multidisciplinary team disagree about the care plan, the Ethics Committee, ethics resource experts, or other resource experts will meet with the team to explore their disagreement and facilitate resolution.

a. If agreement is reached, either to provide or withhold treatment, the decision of the multi-disciplinary team then becomes final.
b. If agreement still is not reached, current treatments will be continued and any other medically necessary treatments provided, until such time that the issue is resolved through court

intervention or the disagreement is otherwise resolved. Court-imposed legal remedies should be sought only in extreme circumstances and as a last resort.

If a unanimous decision is made to proceed with the proposed intervention/treatment, a patient who is not comatose must be notified in writing **(Appendix C - English)** **(Appendix C - Spanish)** that they have been determined to lack capacity to make medical decisions, lack a surrogate decision maker or applicable advance directive, a specific medical intervention has been recommended, and s/he has an opportunity to seek judicial review of these determinations.

The outcome of the multi-disciplinary committee must be documented in the medical record, including the team members and roles of the people who met, and unanimity or not of the decision.

C. Principles of Decision-Making by the Multi-Disciplinary Committee

- Decisions regarding end-of-life care will be limited to patients who are comatose or in a persistent vegetative state, or who are terminally ill with a life expectancy of less than six months.

- This policy does not apply to decisions pertaining to disposition of remains, autopsies, or anatomical gifts. It also does not apply to decisions to be made about the administration of antipsychotic drugs.

- Decisions made by the committee without clear knowledge of an unrepresented patient's specific treatment preferences must be made in the patient's best interest, taking into consideration the patient's personal history, values and beliefs to the extent that these are known. Decisions about treatment should be based on sound medical advice and should be made without the influence of material conflicts of interest. These decisions must be made with a focus on the patient's interests, and not the interests of providers, the institutions, or other affected parties. In this regard, appropriate health care decisions include both the provision of needed medical treatment and the avoidance of non-beneficial or excessively burdensome treatment, or treatment that is medically ineffective or contrary to generally-accepted health care standards.

- Except to the extent that such a factor is medically relevant, any medical treatment decision made pursuant to this policy shall not be biased based on the patient's age, sex, race, color, religion, ancestry, national origin, disability, marital status, sexual orientation, gender identity (or any other category prohibited by law), the ability to pay for health care services, or avoidance of burden to family/others or to society. In determining the best interest of the patient, it is not required that life support be continued in all circumstances, where treatment is otherwise non-beneficial or is medically ineffective or contrary to generally-accepted health care standards, when the patient is terminally ill and suffering, or where there is no reasonable expectation of the recovery of cognitive functions.

- Notification of Patient (Attached form in **Appendix C - English/Appendix C - Spanish)** shall be used for this purpose for a patient who is alert but who lacks capacity for medical decision making. For all other patients lacking capacity, the documentation of patient notification should be made in the electronic health record.
  Notify the patient that:

a. S/he has been determined incapacitated
b. It has been determined that s/he lacks a surrogate decision maker
c. Medical intervention has been prescribed; and
d. S/he has the opportunity to seek judicial review of the above determination

- Legal counsel should be consulted if a decision to withdraw or withhold treatment is likely to result in the death of the patient and the situation arises in any of the following circumstances:
  a. The patient's condition is the result of an injury that appears to have been inflicted by a criminal act.
  b. The patient's condition was created or aggravated by a medical condition.
  c. The patient is pregnant.
  d. The patient is a parent with sole custody or responsibility for a minor child.

The unrepresented patient committee may review and approve proposed patient disposition, when such disposition is considered in the best interest of the patient. The unrepresented patient committee may also sign forms for disposition on behalf of the unrepresented patient, when required.

D. Special Circumstances

Patients in the operating room, under sedation or anesthesia, may require a procedure for which no consent was obtained. The procedure may be emergent, urgent or elective. In cases of emergency, the emergency should be managed as appropriate, with surrogate consent obtained if time allows. If urgent or elective, surrogate consent should be requested prior to the procedure. On the occasion that a surrogate cannot be reached, multiple factors that contribute to risks and benefits must be taken into consideration. Operating Room and procedure area staff should pursue their respective chains of command in order to determine the best course of action for the individual patient.

SOURCE: Consent Manual of California Association of Hospitals and Health Systems, 2016.

Reviewed and Approved by:
Medical Executive Committee – 2/2020

Janine R. E. Vintch, M.D.
President, Professional Staff Association

APPENDIX A:

Non-Exclusive List of "Complex" Procedures that Require Separate, Written Informed Consent

Abortion
Administration of blood and/or blood products
Amniocentesis
Anesthesia (including general and regional anesthesia) and/or deep sedation
Angiography (all)
Arterial Line Insertion
Autopsy
Biopsies (including those done outside of the surgical suite, e.g. uterine, liver, muscle, bone marrow core, pleural, lung-transbronchial and percutaneous, lymph node, skin, nerve, eyelids, external eye, transrectal or perineal prostate biopsy)
Bronchoscopy
Cardiac (all invasive procedures)
Cardioversion
Chemotherapy for cancer treatment
Cholangiography (transhepatic)
Closed reduction of fractures and dislocations done in the Operating Room
Colonoscopy
Cryosurgery
Cutdown (venous or arterial)
Cystoscopy (retrograde pyelography)
Dialysis (First episode of dialysis or change in dialysis modality {e.g., formerly hemodialysis now converted to peritoneal, or visa-versa}, require separate written informed consent. Patients who are receiving chronic dialysis (whether hemodialysis or peritoneal) or who have received prior dialysis during the current hospitalization do not require a separate consent to receive additional dialysis sessions.)
Dilatation of urethral stricture
Discography
Central vein catheterization
Electroconvulsive Therapy (ECT)
Endoscopies requiring conscious sedation
Endoscopic Retrograde Cholangiopancreatography (ERCP)
Esophageal Dilatation
Esophageal Motility
Fluorescein Angiography
Intra-Aortic Balloon Pump
Laparoscopy
Laser Procedures
Lumbar Puncture/Spinal Tap
Myelography
Paracentesis
Percutaneous nephrostomy, gastrostomy, or jejunostomy tube insertion
Pericardiocentesis
Pneumatic Dilation
Polypectomy
Radioactive isotope therapy

Small bowel biopsy
Subdural drainage/aspiration
Surgical Procedures (all)
Swan-Ganz catheter insertion
Thoracentesis

APPENDIX B
LEGAL CONSENT REQUIREMENTS FOR MEDICAL TREATMENT OF MINORS

IF MINOR IS:	*Is parental consent* required?	*Are parents Responsible for Costs?*	*Is minor's Consent Sufficient*	*May M.D. Inform Parents of Treatment* Without minor's Consent?
Unmarried, no special circumstances.	Yes	Yes	No	Yes
Unmarried, emergency care and parents not available (Business and Professions Code Section 2397)	No	Yes	Yes, If capable	Yes
Married or previously married (Family Code Section 7002)	No	No	Yes	No
Emancipated (declaration by court, identification card from DMV) (Family code section 7002, 7050, 7140)	No	See chapter 2	Yes	No
Self-sufficient (15 or over, not living at home, manages own financial affairs) (Family Code Section 6922)	No	No	Yes	See chapter 2
Not married, care related to prevention or treatment of pregnancy, except sterilization (Family Code Section 6925)	No	No	Yes	No
Not married, seeking abortion	No	No	Yes	No
Not married, pregnant, care not related to prevention or treatment of pregnancy and no other special circumstances	Yes	Yes	No	Yes
On active duty with Armed Forces (Family Code Section 7002)	No	No	Yes	No
12 or over, care for communicable reportable disease or condition (Family Code Section 6926)	No	No	Yes	Probably not
12 or over, care for rape (Family Code Section 6927)	No	No	Yes	Yes, usually
Care of sexual assault** (Family Code Section 6928)	No	No	Yes	Yes, usually
12 or over, care for alcohol or drug abuse** (Family Code Section 6929)	No*	Only if parents are participating in counseling	Yes	Yes, usually
12 or over, care for mental health treatment, outpatient only** (Family Code Section 6924)	No	Only if parents are participating in counseling	Yes	Yes, usually
17 or over, blood donation only (/health and safety Code Section 1607.5)	No	No	Yes	Yes, usually

NOTE: A minor is a person under 18 years of age.

* Parental consent is required for minor's participation in replacement narcotic abuse treatment (such as methadone, LAAM or buprenorphine products) in a program licensed pursuant to Health and Safety Code Section 11875 et. Seq. [Family Code Section 6929 (e)].

** Special requirements apply. See Chapter 2 of the Consent Manual.

† Reference: Welfare and Instructions Code Section 14010.

APPENDIX C - English
NOTIFICATION OF A MEDICAL DECISION MADE FOR AN UNREPRESENTED PATIENT AT HARBOR-UCLA MEDICAL CENTER

Patient Name:_____ Medical Record Number: _____ DOB:_____

Your doctor, Dr. _____ has carefully evaluated your physical and medical condition and concluded that you do not have the ability to make decisions about your medical treatment. The hospital has tried to find a family member or friend of yours to make health care decisions for you. The hospital hasn't been able to find anyone to do that. If you have a family member or friend who you want to make health care decisions for you, please tell us.

Your doctor has recommended the following treatment, believing that this is the best treatment for you under the circumstances:

A team of health care professionals, including your doctor and nurses and others, agrees that this is the best treatment for you.

Unless your doctor receives direction otherwise, your doctor intends to proceed with this treatment. You can ask a judge to stop this treatment. You can also ask a judge to let you make your own health care decisions. You can contact a judge at:

Los Angeles County Superior Court
Metropolitan Court House
1945 South Hill Street
Los Angeles, CA 90007

Your assigned hospital social worker, or the Harbor-UCLA patient advocate office may be able to help you contact a judge. If you are interested in this, please notify your nurse or doctor that you want to talk to a social worker or the hospital's patient advocate.

HOSPITAL EMPLOYEE TO COMPLETE:
I gave a copy of this form to the above-named patient on _____ [date] at _____ [time] AM/PM.

Signature: _____

Print name:_____

Original to Patient
Copy in Medical Record

RE: TRATAMENTO MÉDICO Y CONSENTIMIENTO INFORMADO

ANEXO C [Appendix C - Spanish]
NOTIFICACIÓN DE DECISIÓN MÉDICA TOMADA PARA UN PACIENTE NO REPRESENTADO DEL CENTRO MÉDICO HARBOR-UCLA

Nombre del paciente: _____ Número de expediente médico: _____ DOB: _____

Su médico, el Dr. _____ ha realizado una cuidadosa evaluación de su condición física y médica y ha llegado a la conclusión de que usted no tiene la capacidad de tomar decisiones sobre su tratamiento médico. El personal del hospital ha tratado de encontrar algún familiar o amigo suyo que pueda tomar decisiones de atención médica por usted. El personal del hospital no ha conseguido encontrar a nadie que lo haga. Si usted tiene algún familiar o un amigo que desee tomar decisiones sobre su atención médica, le pedimos que nos diga quién es.

Su médico ha recomendado el siguiente tratamiento para usted, considerando que éste es el mejor tratamiento para usted bajo las circunstancias:

Un equipo de profesionales de la salud, en el cual se incluyen su médico, enfermeras y demás, está de acuerdo en que este es el mejor tratamiento para usted.

A menos que su médico reciba instrucciones de lo contrario, su médico tiene pensado continuar con este tratamiento. Usted puede pedir que un juez detenga este tratamiento. También puede pedir que un juez le permita tomar sus propias decisiones de atención médica. Usted se puede poner en contacto con un juez en:

Los Angeles County Superior Court
Metropolitan Court House
1945 South Hill Street
Los Angeles, CA 90007

Su trabajador social, o el personal de la oficina del defensor del paciente del hospital Harbor-UCLA le pueden ayudar a comunicarse con un juez. Si está interesado en hacer esto, por favor informe a su enfermera o a su médico que usted quiere hablar con un trabajador social o con el defensor del paciente del hospital.

UN EMPLEADO DEL HOSPITAL DEBERÁ LLENAR LO SIGUIENTE
HOSPITAL EMPLOYEE TO COMPLETE:
I gave a copy of this form to the above-named patient on _____ [date] at _____ [time] AM/PM.

Signature: _____

Print name: _____

Original to Patient
Copy in Medical Record