REFUSAL OF EXAMINATION AND / OR RECOMMENDED PLAN OF TREATMENT

PATIENT NAME (*TYPE OR PRINT CLEARLY*)	CDCR NUMBER	INSTITUTION

Having been fully informed of the risks and possible consequences involved in refusal of the examination and/or recommended plan of treatment in the manner and time prescribed for me, I nevertheless refuse to accept such examination and/or recommended plan of treatment. I agree to hold the Department of Corrections and Rehabilitation, the staff of the medical department and the institution free of any responsibility for injury or complications that may result from my refusal of this examination and/or recommended plan of treatment, specifically:

Patient's initial	
	I refuse to be transferred to ☐ celled housing ☐ another dormitory ☐ another Institution as part of treatment recommendation by my primary care team to reduce the risk of being infected with the coronavirus disease (COVID-19).

By refusing to be housed in cell housing as recommended by my primary care team,

	I understand that due to my age, I am a high risk for developing serious complications if I get infected with COVID-19.
	I understand that I have <u>one or more</u> medical conditions ~~(s)~~ that makes me high risk for developing serious complications if I get infected with COVID-19.
	I understand that <u>living in</u> places where individuals are in close contact and physical distancing is difficult to follow, such as prison dormitory, will increases my risk of being infected with COVID-19.
	I understand that COVID 19 could lead to serious complications such as lengthy hospitalization and even death.
	I understand that if I change my mind and decided to be housed in celled housing, I will submit a 7362 or talk to a healthcare staff to request for celled housing.

PATIENT SIGNATURE	DATE	☐ PATIENT REFUSES TO SIGN	DATE

WITNESS

NAME OF WITNESS (PRINT/TYPE)		NAME OF WITNESS (PRINT/TYPE)	
WITNESS SIGNATURE	DATE	WITNESS SIGNATURE	DATE

1. <u>Disability Code:</u>	2. <u>Accommodation</u>:	3. <u>Effective Communication</u>:	
☐ TABE score ≤ 4.0	☐ Additional time	☐ Patient asked questions	CDCR #:
☐ DPH ☐ DPV ☐ LD	☐ Equipment ☐ SLI	☐ Patient summed information	Last Name:
☐ DPS ☐ DNH	☐ Louder ☐ Slower	**Please check one:**	First Name: MI:
☐ DDP	☐ Basic ☐ Transcribe	☐ Not reached* ☐ Reached	DOB:
☐ Not Applicable	☐ Other*	*See chrono/notes	

4. <u>Comments:</u>

Unauthorized collection, creation, use, disclosure, modification or destruction of personally identifiable information and/or protected health information may subject individuals to civil liability under applicable federal and state law.