Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Community Health Nursing**	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Informed Refusal of Treatment	Nursing Practice	07-039-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
May 1, 2021 / May 1, 2023	N/A	5
APPLIES TO:		
Nurses and Physicians		

1. BACKGROUND:

Adult and Mature Minor Clients have the right to make the informed decision to refuse treatment for themselves, their minor children, or their wards, even if this refusal is contrary to what the clinician believes to be in their best interest. A thorough discussion of the potential consequences of treatment refusal serves to ensure the client comes to an informed decision. Clear documentation of the client encounter serves to protect the clinician and the Government of Nunavut from a medico-legal risk perspective.

2. POLICY:

2.1 Capable Adult and Mature Minor Clients may refuse treatment on their own behalf and on behalf of their minor children or wards, although some restrictions exist.

2.2 The clinician is responsible for assessing the client's capacity to give or refuse consent, explaining the current health situation, the risks and benefits of the proposed treatment, and the consequences of refusing treatment in plain language. Qualified interpreter services must be offered when the client's first language is not English.

3. PRINCIPLES:

3.1 Clients have the right to make informed decisions about their health, including which treatments they accept or refuse. This could include refusing lifesaving treatment.

3.2 Parents, legal guardians, and substitute decision-makers (SDM) may also make the informed decision to refuse treatment on behalf of their child or ward, although some restrictions exist, such as where the child is a mature minor.

3.3 The client or parent/legal guardian/SDM must demonstrate capacity. They must understand the current health situation, benefits and risks of proposed treatment, and the risks of refusing.

3.5 The client has the right to consent, withdraw consent, or refuse treatment at any time.

3.6 The client has the right to consent to some treatments and refuse others. Refusal of one or more treatments does not mean that all care is arrested.

3.7 It is illegal to impose a treatment when a client with capacity has refused, except in emergencies, or circumstances of court-ordered treatments.

3.8 Signing a "Refusal of Medical Treatment Against Advice" form serves only as documentation that a conversation about the consequences of refusing treatment occurred between clinician and client. It does not prevent the client from seeking care or accepting treatment in the future.

4. DEFINITIONS:

4.1 Clinician: Refers to Community Health Nurse (CHN), Public Health Nurse (PHN), Home Care Nurse (HCN), Mental Health Nurse (MHN), Licensed Practical Nurse (LPN), Nurse Practitioner (NP), or physician.
4.2 Treatment: An intervention intended to protect, promote, or improve the health and wellbeing of a client.
4.3 Capacity: Refers to the ability of a person to understand information provided to them, weigh the benefits and risks of different courses of action, come to a decision, communicate this decision, and understand the potential consequences.
4.4 Minor: A person under the age of nineteen.
4.5 Mature Minor: A person under the age of nineteen, who is assessed by the clinician and deemed to be capable of providing consent or refusing treatment. The mature minor exhibits an understanding of the indication for treatment, what the treatment involves, the benefits and risks of accepting treatment, and the risks of refusing treatment.
4.6 Legal Guardian: A non-parent, court-appointed decision-maker for a minor or dependent adult.
4.7 Ward: A minor or dependent adult who has a court-appointed legal guardian.
4.8 Dependent Adult: An adult who lacks the legal capacity to make health care decisions for themselves, including consent or refusal of treatment.
4.9 Substitute Decision-Maker (SDM): A person who is authorized in writing to make health care decisions for another person, when that person is incapable of making such decisions themselves.

5. PROCEDURE:

5.1 Clients must have capacity to understand the consequences of their decision to decline treatment for themselves or their child/ward.
- 5.1.1 Adults are presumed to have capacity unless there is evidence to the contrary.
- 5.1.2 Mature Minors have the same capacity as Adults, unless there is evidence to the contrary.
- 5.1.3 Minors are presumed to be incapable unless there is evidence to the contrary. A Minor's parent or legal guardian is presumed to be capable of giving or refusing consent.
- 5.1.4 The Director of Child and Family Services (or a designate) gives or refuses consent on behalf of minors in care pursuant to the *Child and Family Services Act*.
- 5.1.5 If a clinician has concerns about an individual's capacity, arrangements must be made to further investigate. This could involve referral to a physician or NP.

5.2 A full discussion of the current health situation, proposed treatment, benefits and risks of treatment, and risks of refusing treatment must occur between clinician and client.
    5.2.1 All the client's questions must be answered in a way that they can understand, avoiding the use of medical jargon.
    5.2.2 Qualified interpreter services must be offered when the client's first language is not English.

5.3 The clinician should explore the client's reason for refusal and determine if there is a way to make treatment acceptable to the client.

5.4 The clinician must request that the client sign a "Refusal of Medical Treatment Against Advice" form (located in Appendix A), formally acknowledging their decision to refuse treatment.
    5.4.1 If the client refuses to sign, the clinician will document this.
    5.4.2 The client should be informed that signing this document does not prevent them from receiving alternate available treatments or from accepting proposed treatment later.

5.5 The clinician must review symptoms of deterioration of condition that would necessitate client's return to the health centre, and any other relevant health teaching.

5.6 The clinician must inform the client that they may change their decision at any time.

5.7 In the case of minors:
    5.7.1 If the parent/guardian of a minor refuses treatment on their behalf, the parent/guardian should be asked to sign the "Refusal of Medical Treatment on Behalf of Minor or Dependent Adult Against Advice" form (located in Appendix B).
    5.7.2 If the parent/guardian of a minor refuses treatment on behalf of the minor that the clinician believes to be essential to health and wellbeing, the clinician must consult Family Services. The clinician must notify the parent/guardian of the intended consultation.
    5.7.3 A mature minor who demonstrates understanding of the purpose, benefits, and risks of a proposed treatment may consent, even with parent/guardian refusal.
    5.7.4 Minors should be advised of their right to obtain assistance from the Office of the Representative for Children and Youth.

5.8 In the case of dependent adults:
    5.8.1 If the guardian/substitute decision-maker of a dependent adult refuses treatment on their behalf, the guardian/SDM should be asked to sign the "Refusal of Medical Treatment Against Advice" form.
    5.8.2 If the clinician believes the refused treatment to be essential to the health and wellbeing of the dependent adult, the clinician must consult Family Services. The clinician must notify the guardian/SDM of the intended consultation.
    5.8.3 If the guardian/SDM is not present or able to be immediately contacted, and there exists imminent threat to life, health, or limb, the clinician has a duty to intervene. The guardian/SDM should be contacted as soon as possible, but provision of lifesaving treatment should not be delayed unless where the clinician has reason to believe that the client would not consent to the planned treatment.
    5.8.4 A guardian/SDM cannot consent to certain treatments, such as psychosurgery, electroconvulsive therapy, sterilization that is not medically necessary, or the removal of organs for the purposes of donation or research. If an adult cannot personally give or

refuse consent to any of these treatments, the clinician cannot proceed without obtaining a court order.

5.9 In rare circumstances, disease control measures such as examination, isolation, and quarantine, might be imposed upon a client without their consent. This would only occur pursuant to an Order of the Chief Public Health Officer. The Chief Public Health Officer may seek an apprehension and treatment order from the Court in circumstances where the burden of risk to client and community outweighs the restriction of the client's individual rights and freedoms.

5.10 There may be instances when a treatment is court-ordered, and adherence by the client is compulsory.

5.11 The clinician must document the following:

5.11.1 A description of the client's current health situation and proposed treatment
5.11.2 Client's reason for refusal of treatment, in their own words
5.11.3 A summary of the discussion had with client about benefits of treatment and potential consequences of refusing
5.11.4 Any consultations that occurred with a physician or NP
5.11.5 Treatments accepted by the client
5.11.6 Education provided to client on reasons to return to health centre or hospital
5.11.7 Any planned follow-up appointments
5.11.8 That the client was informed they may choose to accept treatment and return to the health centre or hospital at any time.
5.11.9 A signed "Refusal of Medical Treatment Against Advice" form if client consents to signing. If the client refuses to sign, this should be documented.
5.11.10 Presence of interpreter if interpreter services were used.

5.12 Procedure must be repeated at each subsequent visit for the same health concern if the client continues to exercise their right to refuse treatment.

6. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

Documentation Standard	Policy 06-008-00
Documentation Standard	Guideline 06-008-01
Child Welfare	Policy 06-016-00
Procedure for Reporting to the Child Protection Worker	Guideline 06-16-01
Non-Urgent Evacuation of Obstetrical Clients	Policy 07-023-00
Non-Urgent Evacuation of Obstetrical Clients	Guideline 07-023-01
Interpreter Services	Policy 06-013-00
Interpreter Services Guidelines	Guideline 06-013-01
Public Health Act	

7. REFERENCES:

Canadian Nurses Protective Society. (2018 Jun). *Consent to treatment: The role of the nurse*. Retrieved from: https://cnps.ca/article/consent-to-treatment/

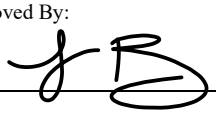
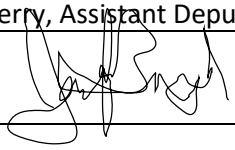
Canadian Medical Protective Association. (2016 Jun). *Consent: A guide for Canadian physicians.* 4th Ed. Retrieved from: https://www.cmpa-acpm.ca/en/advice-publications/handbooks/consent-a-guide-for-canadian-physicians#Informed%20refusal

Canadian Pediatric Society. (2018 Apr 12). *Medical decision-making in pediatrics: Infancy to adolescents.* Retrieved from: https://www.cps.ca/en/documents/position/medical-decision-making-in-paediatrics-infancy-to-adolescence

8. APPENDICES:

A. Refusal of Medical Treatment Against Advice form
B. Refusal of Medical Treatment on Behalf of a Minor or Dependent Adult Against Advice form

9. APPROVALS:

Approved By: 	Date: May 18, 2021
Jennifer Berry, Assistant Deputy Minister – Department of Health	
Approved By: 	Date: May 20, 2021
Jenifer Bujold, Chief Nursing Officer	
Approved By: 	Date:
Dr. Francois de Wet, Medical Chief of Staff, on behalf of the Medical Advisory Committee	

Refusal of Medical Treatment Against Advice

Patient Name: ______________________________

Date of Birth: ______________________________

Health Care Number: __________________________

I, ____ acknowledge that I voluntarily refuse the below
patient name

listed medical evaluation and treatment at ____.
hospital/health centre

1. I have been advised by _______________________________________ that medical care on my
healthcare provider

   behalf is necessary, specifically:

   ☐ Diagnostic tests (list): ____
   ____

   ☐ Medical treatments (list): ____
   ____

   ☐ Transfer to another facility (specify): ____
   ____

2. I understand that refusal of this medical care and assistance could be hazardous to my health, and under certain circumstances, lead to disability or death.

3. I have considered the options presented to me, and, having been informed of the potential risks, have decided to refuse medical treatment at this time.

4. If I change my mind, I will return to the hospital or health centre as soon as possible.

5. By signing this form, I release the Government of Nunavut and the treating health care providers of any liability or medical claims resulting from my decision to refuse treatment against medical advice.

In signing, I confirm that I have read and understand this information and the release of liability.

_____	_____	_____
Signature of Patient	**Print Name**	**Date**
_____	_____	_____
Signature of Witness	**Print Name**	**Date**
_____	_____	_____
Signature of Interpreter	**Print Name**	**Date**

☐ I, _____confirm that I have reviewed the information above with
healthcare provider
the above-named patient. The patient refused to sign the Refusal of Medical Treatment Against Advice form.

_____	_____	_____
Signature of Provider	**Print Name**	**Date**
_____	_____	_____
Signature of Witness	**Print Name**	**Date**
_____	_____	_____
Signature of Interpreter	**Print Name**	**Date**

ᐊᐅᓚᐊᖏᖅᓯᒪᔪᖅ ᐃᓕᓴᕆᔨᖅᑕᐅᓚᐊᕐᓂᖅ ᐅᖃᐅᔨᕆᔨᖅᑕᐅᔪᒪᓂᕐᕕᖅ

ᐊᐅᓚᐊᖏᖅᓯᒪᔪᖅᑐᑦ ᐊᑎᖅᓯᒪ: _____

ᐃᓄᐖᖏᖅᓯᒪᑦ ᐅᓪᓗᖅᓯᒪ: _____

ᐊᐅᓚᐊᖏᖅᓯᒪᔪᑭᓐᓇᐅᑦ: _____

ᐅᕙᖅᓯᒪ, _____ ᓇᓗᓇᐃᖅᓯᐅᖅᓯᒪ ᐃᓱᒪᖅᓱᖅᓴᖅᓯᒪ ᐊᑦᑕᓂ ᑎᑎᕋᖅᓱᒪᔪᕐᓂ ᐊᒃᑲᕋᒃᑯ
ᐊᐅᓚᐊᖏᖅᓯᒪᔪᖅᑐᑦ

ᐊᐅᓚᐊᖏᖅᓯᒪᔪᖅ ᖃᐅᔨᓴᕆᔨᖅᑕᐅᓂᕐᒧᑦ ᐃᓕᓴᕆᔨᖅᑕᐅᓂᕐᒧᑦᓗ ᐅᕙᓂ _____.
ᐊᐅᓚᐊᕐᓇᓗᓴᖅᑎᑦ/ᐊᐅᓚᐊᖏᖅᑎᑦ

1. ᐅᒧᓐᓄ ᐅᖃᐅᔨᓴᐅᖃᐅᔨᐅᕐᓄᓐᓄ _____ ᐊᐅᓚᐊᖏᖅᑎᑦ ᑲᒪᕐᔨᐅᔨᓪᓚᐊᕋᖃᓂᐅᓂᑦ
ᐃᓕᓴᕆᔨᖅᑕᐅᔪᒪᓂᕐᕕᖅ
ᐅᓇ ᐱᔨᔪᑎᑎᓕᓴᕆᓕᓕᒫ:

☐ ᖃᐅᔨᓴᕆᔨᖅᑕᐅᔨᖃᐅᑎᓕᓴᖅᓄᓐᓄ (ᑎᑎᕋᖅᓯᓕᒫ): _____
_____

☐ ᐊᐅᓚᐊᖏᖅᑎᑦ ᐃᓕᓴᕆᔨᖅᑕᐅᓕᓴᖅᓄᓐᓄ (ᑎᑎᕋᖅᓯᓕᒫ):
_____
_____

☐ ᐊᓱᐊᓂᑦ ᐊᐅᓚᐊᖏᖅᓯᒪᓕᐊᕆᔨᖅᑕᐅᓕᓴᖅᓄᓐᓄ (ᓇᓗᓇᐃᖅᓯᓕᒫ): _____
_____

2. ᑐᑭᓱᕐᓄᓐ ᐊᐅᓚᐊᖏᖅᑎᑦ ᑲᒪᕐᔨᐅᔨᓴᕆᔨᖅᑕᐅᔪᒪᓂᕐᕕᖅᑐᑦᓗ ᐃᓅᓱᖅᓂᑦ ᐅᓪᓚᐊᓇᑭᐅᓇᖅᓯᒪᕐᒪᑦ, ᖃᓄᐃᑐᐅᓇᖅᓯᓪᓗ ᐱᔨᔪᑎᖃᖅᓯᓪᓗᒥ, ᐊᔪᕈᑎᖃᖅᑕᓕᐅᖅᓴᓐᓄᓐ ᐃᓅᓱᐅᓂᖅᓯᓪᓗᓂᓕᓂᓂᑦ.

3. ᖃᓄᐃᖅᑐᑭᑎᕆᔭᓂᒃ ᐅᕙᐅᓂᑦ ᐅᖃᐅᔨᓱᐅᓪᓚᐅᖅᑐᓂᒃ ᐃᓱᒪᕆᔭᖅᓱᐅᑭᑎᖃᓪᓚᐅᖅᓴᓐᓄ, ᐊᓪᓚᓪᓗ, ᑐᔪᖅᑎᑕᐅᓪᓚᐅᖅᓴᓐᓄ ᐅᓗᓇᐊᓇᑐᐃᐅᓇᓇᓕᖅᓂᒃ, ᐄᐅᓇᐅᔨᔪᖅ ᐊᐅᓚᐊᖏᖅᑎᑦ ᐃᓕᓴᕆᔨᖅᑕᐅᔪᒪᓂᕐᕕᖅᓴᓐᓄᓐ ᐊᔪᕈᑭᓱᓐᓄᓐ.

4. ᐃᓱᒪᒐ ᐊᓱᔭᕈᒃᑯ, ᐊᐅᓚᐊᖏᖅᓯᒪᓕᐊᕆᔨᖅᑎᑦ ᐊᐅᓚᐊᖏᖅᓯᒪᔨᓪᓕᐅᓂᑦ ᐅᑎᖅᓚᐊᖅᓴᖅᓄᓐᓄ ᐊᔪᕈᐅᓂᕐᒧᑦᓗ ᐊᓱᓕᒪᓕᐊᕈᒪᒪᓕ.

5. ᐅᓇ ᑎᑎᕋᖅᓱᒪᔪᖅ ᐊᑎᓕᐅᕈᒃᑯ, ᓄᓇᕗᑦ ᓴᖅᒪᓕᖅᓴᓂᑦ ᓴᓗᑯᓂᑎᓚᐊᖅᑐᓂᒃ ᐊᓕᒪ ᐃᓕᓴᕆᔨᖅᐃᓚᐊᖅᑐᑦᓗ ᐊᐅᓚᐊᓱᐊᕈᓐᓇᖅᑐᓂ ᐅᕙᓂ ᐊᐅᓚᐊᖏᖅᓯᒪᔪᖅᑐᑦ ᐊᑐᐅᓂᖅᓴᓐᓄᓐ ᐊᔪᕈᑭᓱᓐᓄᓐ ᐊᐅᓚᐊᖏᖅᓯᒪᔪᖅᑐᑦ ᐅᖃᐅᔨᓴᕆᔨᖅᑕᐅᔪᒪᓂᕐᕕᖅᓴᓐᓄᓐ ᐊᔪᕈᑭᓱᓐᓄᓐ.

ᐊᑎᓕᐅᖅᑯᑦ, ᓇᓗᓇᐃᖅᓯᒪᔨᖅ ᐅᖃᓕᒫᖅᓂᒃ ᑐᓴᕐᓗᑎᓪᓗ ᑕᑯᐊᖅ ᑎᑎᕋᖅᓯᒪᓕᕐᒥ ᐊᓪᓚ ᓴᖅᑭᕌᕐᔪᖅ ᐸᓴᕐᕕᐊᓂᖓᓂᕐᒥᑦ.

_____	_____	_____
ᐃᓅᓂᐊᕐᕆᓕᐊᖅᑐᑦ ᐊᑎᓕᕐᕈᓴᓐᓄᑦ	ᐊᑐᑦ ᑎᑎᕋᖅᓯᓗᒍ	ᕿᓚᖅᑐᑦ
_____	_____	_____
ᑕᕈᑐᖅᑎᓕᕈᕕᑦ ᐊᑎᓕᕐᕈᓴᓐᓄᑦ	ᐊᑐᑦ ᑎᑎᕋᖅᓯᓗᒍ	ᕿᓚᖅᑐᑦ
_____	_____	_____
ᑐᐃᓴᕈᑦ ᐊᑎᓕᕐᕈᓴᓐᓄᑦ	ᐊᑐᑦ ᑎᑎᕋᖅᓯᓗᒍ	ᕿᓚᖅᑐᑦ

☐ ᕿᒪᖅᑐ, _____ᓇᓗᓇᐃᖅᓯᒪᔨᖅᑐᒃ ᕋᑯᓪᓗ ᑎᑎᕋᖅᓯᒪᓕᕐᓂᓪ ᕿᑭᒥᕋᖅᑲᑎᑎᕋᖅᑲᕈᑕᑯᑯᓪ
ᐃᓚᕐᕋᖅᓱᐃᓴᖅ
ᕋᑯᓪᓗ ᐊᑎᕋᖅᑕᐅᖅ ᐃᓅᓂᐊᕐᕆᓕᐊᖅᑐᐅᖅ. ᐃᓅᓂᐊᕐᕆᓕᐊᖅᑐᐅᖅ ᐊᑎᓕᕈᕐᒪᖅᑲᓐᓂᑕᐅᖅ ᐃᓅᓂᐊᕆᔨᒥ ᐃᓚᐊᖅᓴᖅᑕᕈᓂᐊᖅᑐᒧᑦ ᐅᕋᕈᐅᓵᖅᑕᕈᓂᐊᖅᑐᒧᑦ.

_____	_____	_____
ᐃᓚᐊᖅᓴᐃᓴᕈᑦ ᐊᑎᓕᕈᕕᑦ ᐊᑎᓕᕐᕈᓴᓐᓄᑦ	ᐊᑐᑦ ᑎᑎᕋᖅᓯᓗᒍ	ᕿᓚᖅᑐᑦ
_____	_____	_____
ᑕᕈᑐᖅᑎᓕᕈᕕᑦ ᐊᑎᓕᕐᕈᓴᓐᓄᑦ	ᐊᑐᑦ ᑎᑎᕋᖅᓯᓗᒍ	ᕿᓚᖅᑐᑦ
_____	_____	_____
ᑐᐃᓴᕈᑦ ᐊᑎᓕᕐᕈᓴᓐᓄᑦ	ᐊᑐᑦ ᑎᑎᕋᖅᓯᓗᒍ	ᕿᓚᖅᑐᑦ

ᑲᑐᑎᓪᓗᒍ ᓄᓇᕗᑦ ᐱᕈᖅᓴᑦᓯᐊᑎᓪᓗᒍ
Building Nunavut Together
Nunavuliuqatigiingniq
Bâtir le Nunavut ensemble

Qingiyauyuq Aanniarnikkut Havautikhainnik Uqautiyugaluaq

Aan**niaqtuq Atia:**___________________________________

Ublua Inuuvia: ___________________________________

Aaniaqtailinirmun Napaa

Uvanga,____ angigiikhimayunga uvamnik ihumaliuqhimayunga qingiuyunga titiraqhimayut ataani

Aanniaqtuq Atia

titiraqhimayuq havautikhat ihivriuqtauhimayut mamitirutikharnik talvani______________________________

aanniarvit/munarhitkut

1. Uqaudjiuvakhimayunga talvanga ___________________________________havautikhaq munagidjutikhanga talvani piutigiyangani

   munarhi ikayukhimaaqtuq

   talvanga atuquyauyuq, naunaiyattiaqhimayut:

   ☐ Ihivriuqtauhimayut Naunaiyaqhimayut (titiraqhimayut):
   ____
   ____

   ☐ Havautikharnik mamitirutikhat (titiraqhimayut:
   ____
   ____

   ☐ Nuutukhauyuq allanun aanniarvingmun (naunaiqlugu):
   ____
   ____

2. Ilihimayunga qingiyauyunga uminga havautikharnik munagidjutikharnik ikayuutikharnik amingnarmanik inuuhimnun, talvuuna mikhaatigun, ayungnautiqarniaqtunga huirniaqtungaluuniit.

3. Ihumaliuqhimayunga pidjutikharnik aituqtauhimayut uvamnun, naunaiyattiaqhimagama ayungnautiqaqtunik, ihumaliuqhimayut qingiyunga havautikharnik tadjanuaq.

4. Ihumaliuffaarmigumik, utirniaqtunga aanniarvikmun munarhitkununluunii qilaminuaq.

5. Atiliugungni una titiraq, atuquyunga Nunavut Kavamanga havautikharnik munarhitkut akiliktuilimaitun havautikharnik akiliktuilimaitun talvuuna ihumaliuyagiikhimayamnik qingiyaangat havautikharnik talvanga munarhit taaktit uqaudjiyainik.

Atiliugupku, angigiikhimayunga taiguqtaga ilihimayungalu una naunaiyagiikhimayuq tautuktitiyaangat allanun akilirialgiit.

_____ _____ _____

Atiliurvikha Aanniaqtuq **Titirattiarlugu Atiit**
Ublua

_____ _____ _____

Atiliurvia Tautuktup **Titirattiarlugu Atiit** **Ublua**

_____ _____ _____

Atiliuqhimayuq Uqaqtiuyi **Titirattiarlugu Atiit** **Ublua**

☐ Uvanga, _____naunaiyagiikhimayuq ihivriuqpakhimayaga naunaiqhimayut titirat qulaani umingalu

munarhi ikayukhimaaqtuq

qulaani atia aanniaqhimayuq. Aanniaqtum qingiyuq atiliugianganik Qingihimayuq Havautikharnik Havautitugumangituq talvanga Uqaudjihimayunin

titirakhaq.

_____ _____ _____

Atiliuqtangit Munarhi **Titirattiarlugu Atiit** **Ublua**

_____ _____ _____

Atiliurvia Tautuktup **Titirattiarlugu Atiit** **Ublua**

_____ _____ _____

Atiliuqhimayuq Uqaqtiuyi **Titirattiarlugu Atiit** **Ublua**

ᑲᑎᒪᔨᑦ ᓄᓇᕗᑦ ᐱᖃᓐᓇᕐᓂᖅᓄᑦ
Building Nunavut Together
Nunavuliuqatigiingniq
Bâtir le Nunavut ensemble

Refus d'un traitement médical contre avis

Nom du patient : _____

Date de naissance : _____

Numéro d'assurance maladie : _____

Je, _____ reconnais que je refuse volontairement
nom du patient

l'évaluation et le traitement médical énumérés ci-dessous à _____.
l'hôpital/au centre de santé

1. J'ai été informé par _____ que des soins médicaux
fournisseur de soins de santé
sur ma personne sont nécessaires, en particulier :

   ☐ Tests de diagnostic (liste) : _____
   _____
   ☐ Traitements médicaux (liste) : _____
   _____
   ☐ Transfert vers un autre établissement (précisez) : _____
   _____

2. Je comprends que le refus de cette assistance et de ces soins médicaux pourrait être dangereux pour ma santé et, dans certaines circonstances, entraîner une invalidité ou la mort.

3. J'ai examiné les options qui m'ont été présentées et, après avoir été informé des risques, j'ai décidé de refuser tout traitement médical pour le moment.

4. Si je change d'avis, je retournerai à l'hôpital ou au centre de santé dès que possible.

5. En signant ce formulaire, je dégage le gouvernement du Nunavut et les fournisseurs de soins de santé concernés de toute responsabilité ou réclamation médicale résultant de ma décision de refuser un traitement contre avis médical.

En signant la présente, je confirme que j'ai lu et compris ces informations et la décharge de responsabilité.

_____	_____	_____
Signature du patient	**Nom (caractères d'imprimerie)**	**Date**
_____	_____	_____
Signature du témoin	**Nom (caractères d'imprimerie)**	**Date**
_____	_____	_____
Signature de l'interprète	**Nom (caractères d'imprimerie)**	**Date**

☐ Je, _____confirme que j'ai passé en revue les informations
fournisseur de soins de santé
ci-dessus avec le patient susmentionné. Le patient a refusé de signer le Refus de traitement médical contre avis.

Formulaire :

_____	_____	_____
Signature du fournisseur de soins de santé	**Nom (caractères d'imprimerie)**	**Date**
_____	_____	_____
Signature du témoin	**Nom (caractères d'imprimerie)**	**Date**
_____	_____	_____
Signature de l'interprète	**Nom (caractères d'imprimerie)**	**Date**

Refusal of Medical Treatment on Behalf of Minor or Dependent Adult Against Advice

Patient Name: ______________________________

Date of Birth: ______________________________

Health Care Number: __________________________

I, ____ acknowledge that I voluntarily refuse the below
name of parent, legal guardian or substitute decision maker

listed medical evaluation and treatment at ____ on
hospital/health centre

behalf of ____ , who is:
name of patient

☐ a child younger than 19 years of age for whom I am the custodial parent or legal guardian

☐ a dependent adult of whom I have substitute decision-making authority

1. I have the legal authority to make medical treatment decisions for the above-named person.
2. I have been advised by ____________________________________ that medical care is necessary for the above named person, specifically:
   ☐ Diagnostic tests (list): ____
   ____
   ☐ Medical treatments (list): ____
   ____
   ☐ Transfer to another facility (specify): ____
   ____
3. I understand that refusal of this medical care and assistance could be hazardous to their health, and under certain circumstances, lead to disability or death.
4. I have consulted with the above-named person and their other parent or caregiver (where appropriate; and
5. I have considered the options presented, and, having been informed of the potential risks, have decided to refuse medical treatment for the above-named person at this time.
6. If I change my mind, I will return with the above-named person to the hospital or health centre as soon as possible.
7. I understand that healthcare providers may be required contact the Department of Family Services concerning this matter.

Patient Name:
Date of Birth:
Health Care Number:

8. By signing this form, I release the Government of Nunavut and the treating health care providers of any liability or medical claims resulting from my decision to refuse treatment for the above-named person against medical advice.

In signing, I confirm that I have read and understand this information and the release of liability.

_____	_____	_____
Signature of Parent, Guardian Substitute Decision Maker	**Print Name**	**Date**
_____	_____	_____
Signature of Witness	**Print Name**	**Date**
_____	_____	_____
Signature of Intepreter	**Print Name**	**Date**

☐ I, _____confirm that I have reviewed the information above with
healthcare provider
the above-named parent/guardian/substitute decision maker. The parent/guardian/substitute decision maker refused to sign the Refusal of Medical Treatment Against Advice form.

_____	_____	_____
Signature of Provider	**Print Name**	**Date**
_____	_____	_____
Signature of Witness	**Print Name**	**Date**
_____	_____	_____
Signature of Interpreter	**Print Name**	**Date**

ᐊᓐᓂᐊᖏᖓᑎ ᐃᓕᐊᖅᑲᖅᑕᐅᓂᐊᖅᑐᖅ ᐅᖅᑲᐅᔪᖅᑕᐅᔪᓐᓇᕐᓂᑐᖅ ᑭᖑᓕᖅᑐᖅᓯᒍ ᐅᑭᐅᕐᓂᑐᖅ ᐅᕐᓂᒍᓐᓂᓕ ᖃᑐᐊᓐᖑᓚᐅᐅᔪᖅ ᐃᓐᓇᐅᑦᓗᓂᓕ

ᐊᓐᓂᐊᕆᐊᖅᑐᑦ ᐊᒻᒪᓗᒃ: _____

ᐃᓅᖏᖓᓕᒃ ᐅᑦᓗᖓᒃ: _____

ᐊᓐᓂᐊᕆᐊᖃᓐᓇᐅᑦ: _____

ᐅᕐᖓᒃ, _____ ᓇᓗᓇᐃᖅᓯᖓᓄᑦ ᐃᓕᒪᖅᓯᖅᓯᓗᒃ ᐊᒋᑦ ᑎᑎᕋᖅᓯᒪᔪᖅ ᐊᐲᖅᑲᖅᑎᑦ
ᐊᖏᓚᔪᖅᑲᓚᐅᐅᔪᖅ, <ᖅᑭᐅᑎᕆᐅᔪᖅ ᐅᕐᓂᒍᓐᓂᑦ ᐃᓕᒪᑕᐅᓚᐅᐅᖏᓐᓄᑦᓯᒪᓕᖅᑐᖅ

ᐊᓐᓂᐊᖏᖓᑎ ᖃᐅᐅᔨᓴᖅᑕᐅᓂᐊᖅᑐᖅᑐᑦᓗ ᐃᓗᐊᖅᓴᖅᑕᐅᓂᐊᖅᑐᑦᓗ ᐅᕐᓂ _____
ᐊᓐᓂᐊᖏᓚᐅᓗᒃᑎ/ᐊᓐᓂᐊᖏᖓᑎ

ᐅᒥᖓ ᑭᖑᓕᖅᑐᐃᑦᓗᓂ _____ , ᐃᒪᐃᑦᑐᖅ:
ᐊᓐᓂᐊᖏᓚᐅᖅᑲᖅᑎᑦ ᐊᒻᒪᖓ

☐ ᓄᑕᖅᖁᖅ 19 ᑐᖓᔪᓂ ᐅᑭᐅᑦᓂᒃ ᐊᖏᓚᔪᖅᑲᓚᐅᐅᑦᓗᖓ <ᖅᑭᐅᑎᕆᐅᑦᓗᖓᓕᒃᓴᓂᓕ

☐ ᖃᐅᑐᖅᑖᓚᔪᐅᔪᖅ ᐃᓐᓇᖅ ᐃᓕᒪᑕᐅᖓᔪᖓᓇᖅᑎᑕᐅᑦᓗᖓ

1. ᐱᔪᓐᓇᐅᑎᖅᑲᓐᖓ ᐊᓐᓂᐊᖏᖓᑎ ᐃᓗᐊᖅᑲᖅᑕᐅᓂᐊᖅᑐᑦᓗᑦ ᐃᓕᒪᑕᐅᓚᔪᓐᓇᐅᖅᓯᒪᓕᖅᑐᖅ ᖃᓄᑦ ᐊᑎᑕᐅᑲᖅᓯᒪᔪᑦᓗᑦ.
2. ᐅᒧᖓᓗ ᐅᖅᑲᐅᔭᕆᐊᑕᐅᑲᖅᑐᖅᓗ _____ ᐊᓐᓂᐊᖏᖓᑎ ᑲᒪᒋᔭᐅᔭᓚᐊᕆᖅᖁᒪᑦ ᖃᓄᑦ ᐊᑎᑐᖅ ᑎᑎᕋᖅᓯᒪᔪᖅ, ᐱᔨᔪᑎᑎᑕᐊᖅᓯᒪᔪᖅ.
   ☐ ᖃᐅᔨᔭᕆᐊᑕᐅᔭᖅᑐᑦᓗᑕᐅᓂ (ᑎᑎᕋᑦᓗᒍ): _____
   _____
   ☐ ᐊᓐᓂᐊᖏᖓᑎ ᐃᓗᐊᖅᑲᖅᑕᐅᓗᑕᐅᓂ (ᑎᑎᕋᑦᓗᒍ): _____
   _____
   ☐ ᐊᓯᐊᓂᑦ ᐊᓐᓂᐊᖏᖓᓕᐊᖅᑕᐅᓗᑕᐅᓂ (ᓇᓗᓇᐃᕋᑦᓗᒍ): _____
   _____
3. ᑐᑭᓯᔪᖓᓕ ᐊᓐᓂᐊᖏᖓᑎ ᑲᒪᒋᔭᐅᔪᓐᓇᕐᓂᐸᑦ ᐃᑲᔪᖅᑕᐅᓂᐊᖅᑐᖅᓂᐸᓕᓐᓂᐊᖅᑐᑦ ᐃᓅᓯᖓᓕ ᐅᓗᓚᐊᓇᖅᑐᒡᓕᒥᐅᓇᕐᓂᑦ, ᖃᓄᐃᓕᐊᓇᕐᓗᓂ ᐱᔪᓐᓇᑎᖅᑕᐅᓂ, ᐊᔪᕈᑎᖅᑕᒥᐅᓇᕐᓂᑦ ᐃᓅᓯᐅᓂᕐᓗᓂᓕᐅᓂᑦ.
4. ᐅᖅᑭᖅᑎᑎᓪᓕᐅᖅᐸᕐᓗ ᖃᓄᑦ ᐊᑎᑕᐅᖅᓯᒪᔪᖅ ᐊᓯᖏᑦᓗ ᐊᖏᓚᔪᖅᑲᓚᐅᐅᔪᓐᓇᑦ ᑲᒪᒋᔭᐅᔭᓚᐅᐅᔪᓐᓇᑦ (ᐱᔾᓚᐊᖅᑲᖅᐸᑦ); ᐊᓴᒪᓗ
5. ᖃᓄᐃᖅᑐᕈᑎᑲᓂᓕ ᐅᑭᐅᓂᑦ ᐅᖅᑲᐅᔭᕆᐊᑕᐅᖅᑐᑦᓂᓕ ᐃᓯᒪᑲᖅᓯᐅᕈᑎᖅᑲᓚᐅᐅᖅᓴᖏᓐᓄᑦ, ᐊᓴᒪᓗ, ᑐᓴᖅᑎᑕᐅᓚᐅᐅᖅᑐᓄᖏᓐᓄᑦ ᐅᓗᓚᐊᓇᑐᐃᓐᓇᓚᐊᓕᓐᓂᓕᓂᓕ, ᐄᓐᓇᐅᔨᓴᖅ ᐊᐅᓂᐊᖏᖓᑎ ᐃᓗᐊᖅᑲᖅᑕᐅᔪᓐᓇᕐᓂᔭᓄᑦ ᖃᓄᐃᓕᐊᓇᕐᓂᑦ ᐊᑎᑕᐅᖅᓯᒪᔪᖅ ᐊᔪᖅᑭᓯᓂᐅᑲᖅᐸᑦ.
6. ᐃᓯᒪᓕ ᐊᓯᔾᔨᕈᑲᑯ, ᐊᓐᓂᐊᖏᖓᓕᐊᓗᓐᓗᓕᑦ ᐊᓐᓂᐊᖏᖓᓕᓐᓂᐊᖅᑐᑦ ᖃᓄᐃᓕᐊᓇᕐᓂᑦ ᐊᑎᖅᑲᖅᑐᑦ ᐅᑎᖅᑎᑎᓂᐅᔪᖅᐸᑦ ᐊᔪᖅᓇᐅᓂᐅᑐᑲᖅᐸᑦ.
7. ᑐᑭᓯᔪᖓᓕ ᐊᓂᐊᓯᐅᖅᑲᐱᑦ ᐃᓄᓕᓗᓇᔾᑯᓂᓂ ᑐᓴᖅᑎᕐᑎᓇᐊᖅᑲᐃᓐᓇᓚᐊᖅᖁᒪᒡᒐ ᑕᒪᓐᓇ ᐱᔾᔪᑎᑎᓪᓕᐊᓕ.

8. ᐅᓇ ᑎᑎᕋᖅᓯᒪᔪᖅ ᐊᑎᑕᐅᐅᓕᑯᑯ, ᓄᓇᕗᑦ ᓴᖅᒪᓕᖓᓄᑦ ᓇᔾᔨᑎᑎᓂᐊᖅᑐᖅᓂᓕ ᐊᓐᓂᐊᖏᖓᑎ ᐊᐅᓚᑦᓴᐃᓇᐅᖅᑐᑦ ᐊᓐᓂᐊᖏᖓᑎ ᐃᓗᐊᖅᑲᖅᑕᐅᓂᐊᖅᑐᖅᑐᑦᓗ ᐅᖅᑲᐅᔪᖅᑕᐅᓚᐅᐅᖅᓴᖏᓐᓄᑦ ᖃᓄᐃᓕᐊᓇᕐᓂᑦ ᐊᑎᑕᐅᖅᓯᒪᔪᖅ.

ᐊᓐᓂᐊᕐᓂᖅ ᐊᑎᖅᑐ:
ᐃᓄᖅᓴᐃᓐ:
ᐊᓐᓂᐊᕐᓂᐊᕐᓇᐅᑦ;

ᐊᑎᓕᐅᕆᔨd, ᓇᓗᓇᐃᖅᓯᖅᑐᖅ ᐅᖅᑲᓕᒫᖅᓂᓂ ᑐᐱᓯᓗᓕᓗ ᑦᔨdᐊ ᑎᑎᕋᖅᓯᒪᔪ ᐊᒻᒪ ᓴᔨdᕋᑎᖅᑐᖅ ᕿᓯᕆᐅᔪᖅᓇᕋᓂᕐᒥᖅ.

_____	_____	_____
ᐊᖅᑕᔪᖅbᓇᓴᓕ, <ᖅᑭᐸᐅᓕ ᐊᑎᓕᐅᕆᔨᖅᑐᑕ ᐃᓱᒪᓕᐅᓇᐅᐅᖅᑎᒍᖅᑐᖅ	ᐊᑲᑦ ᑎᑎᕋᖅᓗᒍ	ᐅᓪᓗᖅᑕ
_____	_____	_____
ᑕᐅᑐᖅᑎᑎᕆᐅᔪᑦ ᐊᑎᓕᐅᕆᔨᖅᑐᑕ	ᐊᑲᑦ ᑎᑎᕋᖅᓗᒍ	ᐅᓪᓗᖅᑕ
_____	_____	_____
ᑐᐃᓴᐅᓕ ᐊᑎᓕᐅᕆᔨᖅᑐᑕ	ᐊᑲᑦ ᑎᑎᕋᖅᓗᒍ	ᐅᓪᓗᖅᑕ

□ ᐅᖅᑖᖅᑐ, _____ᓇᓗᓇᐃᖅᓯᖅᑐᖅ ᕋdᓪᓚᓂ ᑎᑎᕋᖅᓯᒪᔪᓪᓕ ᕿᑎᕋᖅᑕᐅᓚᕆᑎᒍᓪᓕ
ᐃᓗᐊᖅᑲᐃᐃᓴᓗᓐ
ᕋdᓪᓚᓂ ᐊᑎᓕᐅᕐᓂᖅᓯᒪᔪᓪᓗ ᐊᖅᑕᔪᖅbᓇᓴᐅᔪᖅ/<ᖅᑭᐸᑎᓴᐅᔪᖅ/ᐃᓱᒪᓕᐅᓇᐅᐅᖅᑎᒍᖅᑐᖅ.
ᐊᖅᑕᔪᖅᔪᖅbᓇᓴᐅᔪᖅ/<ᖅᑭᐸᑎᓴᐅᔪᖅ/ᐃᓱᒪᓕᐅᓇᐅᐅᖅᑎᒍᖅᑐᖅ ᐊᑎᓕᐅᕈᒪᓕᐅᖃᖅᑎᒪᓕᑦ ᐊᓐᓂᐊᕐᓇᖅᑐᖅ ᐃᓗᐊᖅᑲᐃᐃᓴᓗᓐ ᐅᖅᑲᐅᔪᖅᑕᐅᔪᒪᖃᖅᑎᑦ.

ᐃᓗᐊᖅᑲᐃᐃᓴᐅᑦ ᐊᑎᓕᐅᕆᔨᖅᑐᑕ	ᐊᑲᑦ ᑎᑎᕋᖅᓗᒍ	ᐅᓪᓗᖅᑕ
_____	_____	_____
ᑕᐅᑐᖅᑎᑎᕆᐅᔪᑦ ᐊᑎᓕᐅᕆᔨᖅᑐᑕ	ᐊᑲᑦ ᑎᑎᕋᖅᓗᒍ	ᐅᓪᓗᖅᑕ
_____	_____	_____
ᑐᐃᓴᐅᓕ ᐊᑎᓕᐅᕆᔨᖅᑐᑕ	ᐊᑲᑦ ᑎᑎᕋᖅᓗᒍ	ᐅᓪᓗᖅᑕ

Qingiyauyuq Aanniarnikkut Havautikhainnik Iningniungitunik Munagiyauyunikluuniit Iningnirmin talvanga Uqautiyugaluaq

Aanniaqtuq Atia:___________________________________

Ublua Inuuvia: ___________________________________

Aaniaqtailinirmun Napaa

Uvanga,____ angigiikhimayunga uvamnik ihumaliuqhimayunga qingiuyunga titiraqhimayut ataani

Atia angajuqqaaq, munaqtiuyuq allanikluuniit ihumaliuqtiuyuq munagiyainik

titiraqhimayuq havautikhat ihivriuqtauhimayut mamitirutikharnik talvani______________________________ talvuuna

aanniarvit/munarhitkut

pidjutigiplugit ____ tamnauyuq:

Atia Anniaqtup

☐ nutaraq nukakhitqiyaq 19nik ukiuqangituq taima angayuqaanguyunga munaqtiuyungaluuniit

☐ munagihimaaqtaqqut iningniq taima ihumaliuqtiuyunga munagiyamnik

1. Maligaliqinikkut akhurutiqaqtunga aanniaqtun havautikharnik ihumaliuqtukhauyunga atia titiaqhimayunun qulaani.
2. Uqaudjiyauyunga tapfuminga _____________________________________havautikharnik munagidjutikhainik qulaani atia titiraqhimayuq, naunaiyattiaqhimayuq:

   ☐ Ihivriuqtauhimayut Naunaiyaqhimayut (titiraqhimayut):

   ____

   ____

   ☐ Havautikharnik mamitirutikhat (titiraqhimayut:

   ____

   ____

   ☐ Nuutukhauyuq allanun aanniarvingmun (naunaiqlugu):

   ____

   ____
3. Ilihimayunga qingiyauyunga uminga havautikharnik munagidjutikharnik ikayuutikharnik amingnarmanik inuuhimnun, talvuuna mikhaatigun, ayungnautiqarniaqtunga huirniaqtungaluuniit.

Aanniaqtuq Atia:
Ublua Annivia:
Aaniaqtailinirmun Napaa

4. Tutqikhaivakhimayunga tamna qulaani atia titiraqhimayuq inuk aipaitlu angajuqqaangit munaqtiuyutluuniit (ihuaqtumi itukhaq; unalu
5. Ihumaliuqhimayunga pidjutikharnik aituqtauhimayut uvamnun, naunaiyattiaqhimagama ayungnautiqaqtunik, ihumaliuqhimayut qingiyunga havautikharnik qulaani atia inuk titiraqtauhimayuq tadjanuaq.
6. Ihumaliuffaarmigumik, utirniaqtunga qulaani atia inuk titiraqtauhimayuq aanniarvikmun munarhitkununluunii qilaminuaq.
7. Ilihimayunga munarhit tunihimaaqtun munagidjutikharnik hivayagiaqaqtaat Havagviat Inulirijikkut ihumaginikkut una ihumagiyauyumik.

8. Atiliurnikkut una titiraq, aulatitigiaqaqtunga Nunavut Kavamanga munagihimaaqtun munarhitkut kitunikliqaak akiliktauyukharnik havautikharnik akiligiaqaqtunik talvani ihumaliuqhimayuni qingiyuniklu havautikharnik qaangani atia titiraqhimayuq talvanga havautikharnik uqaudjiyukharnik.

Atiliugupku, angigiikhimayunga taiguqtaga ilihimayungalu una naunaiyagiikhimayuq tautuktitiyaangat allanun akilirialgiit.

_____ _____ _____

Atiliurvikha Angajuqqaaq, Munaqtiuyuq Himautauyumin Ihumaliuqnikkut Ihumaliuqtimin Ublua **Titirattiarlugu Atiit**

_____ _____ _____

Atiliurvia Tautuktup **Titirattiarlugu Atiit** **Ublua**

_____ _____ _____

Atiliuqhimayuq Uqaqtiuyi Ublua **Titirattiarlugu Atiit**

☐ Uvanga, _____naunaiyagiikhimayuq ihivriuqpakhimayaga naunaiqhimayut titirat qulaani umingalu

munarhi ikayukhimaaqtuq

Qaangani atiq angajuqqaaq/munaqtiuyuq/himautikhaq ihumaliuqtiuyuq. Tamna

Aanniaqtuq Atia:
Ublua Annivia:
Aaniaqtailinirmun Napaa
angayuqaaq/munati/himautihimayuq ihumaliuqti

ihumaliuqtiuyuq anniaqtum qingiyuq atiliugianganik Qingihimayuq Havautikharnik Havautitugumangituq talvanga Uqaudjihimayunin titiraqharni.

_____	_____	_____
Atiliuqtangit Munarhi	**Titirattiarlugu Atiit**	**Ublua**
_____	_____	_____
Atiliurvia Tautuktup	**Titirattiarlugu Atiit**	**Ublua**
_____	_____	_____
Atiliuqhimayuq Uqaqtiuyi	**Titirattiarlugu Atiit**	
Ublua		

ᑲᑐᑎᑐᒍ ᓄᓇᕗᑦ ᐱᕈᖅᓴᖅᑕᐅᑎᓪᓗᒍ
Building Nunavut Together
Nunavu liuqatigiingniq
Bâtir le Nunavut ensemble

Refus d'un traitement médical au nom d'un mineur ou d'un adulte à charge contre avis

Nom du patient : ___________________________________

Date de naissance : ___________________________________

Numéro d'assurance maladie : ______________________________

Je, ____ reconnais que je refuse volontairement
nom du parent, du tuteur légal ou du mandataire spécial

l'évaluation et le traitement médical énumérés ci-dessous à __________________________________au
l'hôpital/au centre de santé

nom de ____, qui est :
nom du patient

☐ un enfant âgé de moins de 19 ans dont je suis le parent ayant la garde ou le tuteur légal

☐ un adulte à charge pour lequel je dispose d'un pouvoir de décision au nom d'autrui

1. J'ai l'autorité légale de prendre les décisions relatives au traitement médical de la personne susmentionnée.
2. J'ai été informé par _______________________________________ que des soins médicaux sont nécessaires pour la personne susmentionnée, en particulier :
   ☐ Tests de diagnostic (liste) : ____
   ____
   ☐ Traitements médicaux (liste) : ____
   ____
   ☐ Transfert vers un autre établissement (précisez) : ____________________________________
   ____
3. Je comprends que le refus de cette assistance et de ces soins médicaux pourrait être dangereux pour sa santé et, dans certaines circonstances, entraîner une invalidité ou la mort.
4. J'ai consulté la personne susmentionnée et son autre parent ou fournisseur de soins (le cas échéant).
5. J'ai examiné les options qui ont été présentées et, après avoir été informé des risques, j'ai décidé de refuser tout traitement médical pour la personne susmentionnée pour le moment.
6. Si je change d'avis, je retournerai à l'hôpital ou au centre de santé avec la personne susmentionnée dès que possible.
7. Je comprends que les fournisseurs de soins de santé peuvent être tenus de contacter le ministère des Services à la famille à ce sujet.

Nom du patient :
Date de naissance :
Numéro d'assurance maladie :

8. En signant ce formulaire, je dégage le gouvernement du Nunavut et les fournisseurs de soins de santé concernés de toute responsabilité ou réclamation médicale résultant de ma décision de refuser un traitement pour la personne susmentionnée, et ce, contre avis médical.

En signant la présente, je confirme que j'ai lu et compris ces informations et la décharge de responsabilité.

_____	_____	_____
Signature du parent/tuteur Mandataire spécial	**Nom (caractères d'imprimerie)**	**Date**
_____	_____	_____
Signature du témoin	**Nom (caractères d'imprimerie)**	**Date**
_____	_____	_____
Signature de l'interprète	**Nom (caractères d'imprimerie)**	**Date**

☐ Je, _____confirme que j'ai passé en revue les informations
fournisseur de soins de santé

ci-dessus avec la personne susmentionnée/le tuteur/le mandataire spécial. Le parent/le tuteur/le mandataire spécial a refusé de signer le formulaire de Refus de traitement médical contre avis.

_____	_____	_____
Signature du fournisseur de soins de santé	**Nom (caractères d'imprimerie)**	**Date**
_____	_____	_____
Signature du témoin	**Nom (caractères d'imprimerie)**	**Date**
_____	_____	_____
Signature de l'interprète	**Nom (caractères d'imprimerie)**	**Date**