NOTE: HEALTHCAP DOES NOT SUPPORT THE USE OF DIETARY WAIVERS.

Permitting a resident to violate a physician's order would likely be seen as evidence of negligence should a claim be asserted later.

The State Operations Manual, Appendix PP @ §483.25(d) provides the following warning related to resident waivers:

"Verbal consent or signed consent/waiver forms **do not eliminate a facility's responsibility to protect a resident from an avoidable accident, nor does it relieve the provider of its responsibility to assure the health, safety, and welfare of its residents.** While Federal regulations affirm the resident's right to participate in care planning and to refuse treatment, the regulations **do not create the right for a resident or representative to demand the facility use specific medical interventions or treatments that the facility deems inappropriate. The regulations hold the facility ultimately accountable for the resident's care and safety."**

HealthCap
RISK MANAGEMENT SERVICES

Informed Consent & Waiver of Physician's Order
(Texture-Modified Diet)

Resident Name:_____ Patient Date of Birth:_____

Room Number:_____

Relevant Diagnosis: _____

Relevant Order and Date: _____

- I understand that my doctor has ordered a specialized diet as part of my treatment plan to reduce my increased risk of adverse health consequences.
- This diet order is considered important to my health because my medical diagnosis includes an increased risk that I will experience chewing and/or swallowing difficulties.
- I understand and accept that eating foods of a texture that are not recommended by my doctor and speech-language pathologist could result in choking, aspiration, pneumonia, and/or death.
- I understand and accept that if I were to aspirate and/or choke, that there is a heightened possibility I would sustain irreparable injury, including possible death.
- Despite these significant risks, I decline to adhere to my physician's diet order
- I understand the risks of noncompliance and have been sufficiently counseled on these risks
- I accept responsibility for any health condition that may result from refusal to comply with my physician's diet order

Knowing and fully understanding these risks, including the risk of death, I release _____ [Provider] from liability related to any consequence that could result from my decision to refuse the recommended diet and resultant harm I may sustain as a consequence of my refusal.

_____ **Date**_____
Patient
(or Legally Validated Responsible Party – attach a copy of legal document supporting authority to make medical decisions)

_____
Facility Representative **Date**

_____
Witness 1 **Date**

_____
Witness 2 **Date**

Released 11/21/2022