Oneida Healthcare
EXCEPTIONAL CARE ... ALWAYS

Name: _____

MRUN #: _____ DOB: _____

Date of Service: _____ ACCT#: _____

If no label, write patient information in this box.

Parent's Bill of Rights

ONEIDA HEALTHCARE, IN RECOGNITION OF ITS DESIRE TO PROVIDE EACH OF OUR PATIENTS WITH THE HIGHEST QUALITY MEDICAL CARE AND SATISFACTION WITH OUR HOSPITAL SERVICES, PLEDGES THEREFORE, AS A PARENT, LEGAL GUARDIAN OR PERSON WITH DECISION-MAKING AUTHORITY FOR A PEDIATRIC PATIENT RECEIVING CARE IN THIS HOSPITAL, THAT YOU HAVE THE RIGHT, CONSISTENT WITH THE LAW, TO THE FOLLOWING:

1. To inform the hospital of the name of your child's primary care provider, if known, and have this information documented in your child's medical record.
2. To be assured your hospital will only admit pediatric patients to the extent consistent with your hospital's ability to provide qualified staff, space, and size-appropriate equipment, necessary for the unique needs of pediatric patients.
3. To allow at least one parent or guardian to remain with your child at all times, to the extent possible given your child's health and safety needs.
4. That all test results completed during your child's admission or emergency room visit be reviewed by a physician, physician assistant, or nurse practitioner who is familiar with your child's current condition.
5. That your child is not to be discharged from our hospital or emergency room until any tests that could reasonably be expected to yield critical value results are reviewed by a physician, physician assistant, and/or nurse practitioner and communicated to you or other decision- makers, and your child, if appropriate. Critical value results are results that suggest a life-threatening or otherwise significant condition that requires immediate medical attention.
6. That your child is not to be discharged from our hospital or emergency room until you or your child, if appropriate, receives a written discharge plan, which will also be verbally communicated to you and your child or other medical decision-makers. The written discharge plan will specifically identify any critical results of laboratory or other diagnostic tests ordered during your child's stay and will identify any other tests that have not yet been concluded.
7. To be provided critical value results and the discharge plan for your child in a manner that reasonably ensures that you, your child (if appropriate), or other medical decision-makers understand the health information provided in order to make appropriate health decisions.
8. That your child's primary care provider, if known, is to be provided all laboratory results of this hospitalization or emergency room visit.
9. To request information about the diagnosis or possible diagnoses that were considered during this episode of care and complications that could develop as well as information about any contact that was made with your child's primary care provider.
10. To be provided, upon discharge of your child from the hospital or emergency department, with a phone number that you can call for advice in the event that complications or questions arise concerning your child's condition.

I understand these rights as provided to me:

_____ _____

SIGNATURE OF PARENT / GUARDIAN DATE TIME

_____ _____

SIGNATURE OF HOSPITAL REPRESENTATIVE DATE TIME