STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Patient's Last Name		
Patient's First Name	Patient's Middle Name/Initial	
Patient's Date of Birth (MM/DD/YYYY)		
Street or Residential Address		
City	State	Zip code -

Patient Statement (SIGNATURE AND DATE REQUIRED)

I, _____, hereby certify that:

I am voluntarily refusing, at my own insistence, the offer or administration of any opioid medications at any time, including during an emergency situation during which I am unable to speak for myself.

I understand the risks and benefits of my refusal, including the liability limitations under Public Act 17-131 § 4 concerning a prescribing practitioner who relies on this VNOD.

I understand that notwithstanding this VNOD an emergency department prescribing practitioner shall not be held liable for civil damages or subject to criminal prosecution or deemed to have violated the standard of care for such practitioner's profession for issuing a prescription for or administering a controlled substance containing an opioid under certain circumstances described under the Connecticut Department of Public Health's Voluntary Non-Opioid Directive guidance located at: www.ct.gov/dph.

I also understand that I may effectively revoke this certification at any time orally or in writing.

_____ _____

Signature of Patient Date

I hereby appoint the following ☐ duly authorized guardian ☐ health care proxy, (First and Last Name) _____, to override a previously recorded VNOD, including this VNOD, regarding me. Said person may revoke such VNOD orally, or in writing, for any reason, at any time.

SIGNATURE AND DATES (ALWAYS REQUIRED)

I am a prescribing practitioner, as defined in Conn. Gen. Stat. § 20-14c, for the above named patient. I acknowledge that the above-named patient voluntarily filed this VNOD with me on mm/dd/yyyy)_____.

_____ _____ _____

Printed Name Prescribing Practitioner Signature of Prescribing Practitioner Date

_____

Address of Prescribing Practitioner – Street, City, State, Zip Code

_____ ☐ Checking this box indicates the VNOD has been revoked ___verbally ___in writing. _____

Telephone Number of Prescribing Practitioner Date

Voluntary NonOpioid Directive (VNOD)

First Copy: To be kept by patient I Second Copy: To be kept in patient's permanent medical record

If the person completing this form is currently enrolled in treatment for substance use disorder, appropriate consents must comply with HIPAA and 42 CFR Part 2.