

Patient Identification

Name: _____

Medical Record Number: _____

Birthdate: _____

INFORMED REFUSAL

You have the right and obligation to make decisions concerning your healthcare. Your physician has the duty to provide you with the necessary information and advice, but because this affects you, you must enter into the decision-making process. Please feel free to ask any questions. This form has been designed to acknowledge your refusal of treatment recommended by your physician, after being informed of the risks and benefits.

(1) My physician, Dr. _____ (and any physician associate/assistant involved in my care) explained to me the following test/procedure/treatment: (No abbreviations): _____

(2) My physician has explained to me that the potential benefits of the test/procedure/treatment include:

The risks are: _____

(3) Despite my physician's recommendation, I refuse to consent to this medical treatment. My physician has explained the following risk to my refusal. They include, but are not limited to: _____

By signing this form, I acknowledge that my medical condition has been evaluated and explained by my physician, who has recommended treatment as stated above, and that my doctor has explained to me the potential benefits of such treatment and the risks associated with it, as well as the probable risks of not following the recommended treatment, which I fully understand. In spite of this understanding, I refuse to consent to this medical treatment.

Signature of Patient (or person authorized to sign for patient)

Date/Time

Relationship of Person Authorized to Consent for Patient

Signature of Responsible Practitioner/Physician

Date/Time

** If a patient is a minor, unable to sign, or decisionally incapacitated to give consent, relationship of person authorized to give consent must be stated.*