Informed Refusal Form

Patient's Name _____ DOB_____

1. My provider,_____, has suggested that I have the following test/procedure/treatment: _____ .

2. He/she told me:

- How the test/procedure/treatment will help me which include:

- What problems I could have if I have the test/procedure/treatment which include:

- Other choices instead of the test/procedure/treatment which include:

3. My provider has told me about the following danger to my health if I do not have the test/procedure/treatment. These include:

4. My reason for saying no to the test/procedure/treatment is:

5. By signing this form, I admit that my provider has clearly told me about my health problems, the dangers and the help I could receive from the test/procedure/treatment and has answered all of my questions.

I admit that my provider has also told me about the dangers to my health if I say no to the test/procedure/treatment. I understand the dangers to my health and my provider has answered all of my questions.

Regardless of my provider's suggestion, I do not want to have this test/procedure/treatment.

_____ _____

Date/Time Signature of Patient or Authorized Individual

_____

Relationship of Authorized Individual to Patient

6. I have explained to the Patient/Authorized Individual the risks, benefits and alternatives of the proposed course of action as well as the risks and consequences of not following the advised course of action. The Patient/Authorized Individual has been given the opportunity to ask questions and I have answered these questions.

_____ _____

Date/Time Signature of Provider