

## REFUSAL TO CONSENT TO TREATMENT, MEDICATION, OR TESTING

*Individuals are legally entitled to exercise their freedom of choice by choosing not to undergo a recommended course of treatment, medication, or testing.*

Patient's  
Initials

\_\_\_\_\_ It has been recommended to me that I should undertake the following treatment, medication, or testing ordered by my healthcare provider(s):

\_\_\_\_\_

\_\_\_\_\_ I have been advised of the risks and benefits of the treatment, medication, or testing and all appropriate alternatives, including:

\_\_\_\_\_

\_\_\_\_\_ I have been advised of the risks and consequences of refusing the recommended treatment, medication, or testing, including:

\_\_\_\_\_

\_\_\_\_\_ I have had all of my questions answered by my healthcare provider(s):

\_\_\_\_\_ (Name[s] of Healthcare Providers[s])

Having considered all of my options and understanding the risks of declining the treatment, medication, or testing, I have decided not to undergo the proposed course of therapy.

\_\_\_\_\_ Patient or Legal Representative Signature/Date/Time

\_\_\_\_\_ Print Patient's or Legal Representative's Name

\_\_\_\_\_ Patient's Date of Birth

\_\_\_\_\_ Legal Representative's Relationship to Patient

\_\_\_\_\_ Witness Signature/Date/Time

\_\_\_\_\_ Print Witness's Name

I certify that I have explained the nature, purpose, benefits, material risks, and alternatives to the proposed treatment, medication, or testing and the risks and consequences of not proceeding, have offered to answer any questions, and have fully answered all such questions. I believe that the patient/legal representative (circle one) fully understands what I have explained.

\_\_\_\_\_ Healthcare Provider Signature/Date/Time

J131871 01/22