

# REFUSAL TO CONSENT TO TREATMENT

Patient's  
Initials

\_\_\_\_\_ I understand and refuse the following treatment, medication, or testing ordered by my physician(s):

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\_\_\_\_\_ I am aware that this is against the advice of my physician.

\_\_\_\_\_ I am aware of the risks associated with this action, including the fact that my condition may worsen.

\_\_\_\_\_ I hereby release Dr. \_\_\_\_\_, and his/her medical staff from all responsibility for any ill effects that may result from my refusal of treatment, medication, testing, or care.

\_\_\_\_\_ The doctor has answered all of my questions.

I certify that I have read and understand the above and that all blanks were filled in prior to my signature.

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

\_\_\_\_\_  
Relationship to Patient

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

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

I certify that I have explained the nature, purpose, benefits, material risks and alternatives to the proposed treatment 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.

\_\_\_\_\_  
Physician Signature/Date/Time

\_\_\_\_\_ copy given to patient  
initial

\_\_\_\_\_ original placed in chart  
initial

9/05  
Revised 12/05, 1/06, 3/08

*This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice site(s), CMS and Joint Commission requirements and legal requirements of your individual state(s).*