REFUSAL TO CONSENT TO 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 physician(s):

_____

_____

_____

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

_____

_____

_____

_____ I have had all of my questions answered by Dr. _____.

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 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, 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.

_____
Physician Signature/Date/Time

_____ copy given to patient
initial

_____ original placed in chart
initial