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     _______ original placed in chart
initial    initial