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

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_____ 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

____

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.

____

Physician Signature/Date/Time

SAMPLE

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 accreditation requirements, if any, and legal requirements of your individual state(s).