

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