Discussion and Refusal of Treatment Form - SAMPLE

Patient Name: ___________________________ Date of Birth: ______________________

I am being provided this information and refusal form to document the discussion and my understanding regarding my diagnosis, the treatment or testing recommended for me, and the consequences of my refusal. I understand that I may ask any questions I wish regarding the recommended treatment and my refusal of such.

Nature of Recommended Treatment/Testing

It has been recommended to me that I have the following treatment or testing done:

________________________________________________________________________

This recommendation is based upon an examination, the results of diagnostic tests, and/or my doctor’s knowledge of my medical history and the nature of my illness, which is:

__________________________________________________________

(Diagnosis)

The benefit of the recommended treatment is: __________________________

Alternative Treatment (If Any):

The recommended treatment was chosen because it best suits my needs. Some reasonable alternative ways to treat this condition are:

_____________________________________________________________________

_____________________________________________________________________

______ No other reasonable treatment option exists for my condition.

Risks of the Recommended Treatment:

I understand that no medical or surgical treatment or testing is completely risk free and that there are some typical complications that can occur after the recommended treatment. These complications may include, but are not limited to:

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

Updated: January 2019
RISKS OF NOT HAVING THE RECOMMENDED TREATMENT OR TESTING:

I understand that complications to my health (including some that may not be known at this time) may occur if I do NOT proceed with the recommended testing. These complications include but are not be limited to:

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

I, _______________________________________________, have received information about the proposed treatment.

I have discussed my treatment with Dr. ___________________________ and have been given an opportunity to ask questions and have them answered to my satisfaction. I understand the nature of the recommended treatment or testing, the alternative options, if any, the risks of the recommended treatment, and the possible consequences of my refusal of care.

I do NOT wish to proceed with the above recommended treatment or testing. I also understand that I may change my mind. If I do, I will contact the doctor.

Signed: _________________________________ Date: _______________
(Patient)

Signed: _________________________________ Date: _______________
(Parent or Guardian/Relationship)

Signed: _________________________________ Date: _______________
(Treating Physician)