Sample Refusal of Treatment/Procedure Form

Instructions

This form should be signed by the patient or authorized party if he/she refuses any surgical procedure or medical treatment recommended by his/her physician or provider. If the patient or authorized party not only refuses the treatment/procedure, but also refuses to sign this form, note this fact in the patient healthcare information record.

1. I have been advised by my physician/provider *(insert name)* _____, that the following treatment/procedure should be performed upon me *(insert name of treatment/procedure):* _____

   _____

2. Nature of the Recommended Treatment/Procedure

   This recommendation is based on physical examination(s), diagnostic test results and my physician's/provider's knowledge of my medical history. My needs and desires have also been taken into consideration. The treatment/procedure is necessary due to:

   _____

   The intended benefit(s) resulting from this treatment/procedure is (are): _____

   _____

   The prognosis, or likelihood of treatment/procedure success is: _____

   _____

   The consequences of not proceeding with the recommended treatment/procedure are: _____

   _____

3. Alternative Treatment/Procedure *(check one):*

   ☐ The treatment/procedure recommended for me was chosen because it is believed to address my medical condition. I understand that alternative treatment/procedure options include: _____

   _____

   ☐ No other reasonable treatment/procedure options exist for my condition.

4. I have read the following educational materials provided to me *(list materials, if applicable):*

   _____

5. Risks of Not Having the Recommended Treatment/Procedure:

   I understand that complications to my health may occur if I do not proceed with the recommended treatment/procedure. These complications include: _____

   I have had an opportunity to ask questions about these risks and any other risks I have heard or thought about.

6. Acknowledgment

   I, _____, have received information about the proposed treatment/procedure. I have discussed my treatment/procedure with my provider/physician and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment/procedure, alternate treatment/procedure options, and the risks of the recommended treatment/procedure, and my refusal of care.

7. My reason for refusal is as follows: _____

(continued)

8. I personally assume the risks and consequences of my refusal, and release for myself, my heirs, executors, administrators or personal representatives those physicians/providers who have been consulted in my case as well as *(insert name of medical practice)* _____, its officers, agents and employees, from any and all liability for ill effects that may result from my refusal to consent to the performance of the proposed treatment(s)/procedure(s).

I acknowledge that I have read this document in its entirety, that I fully understand it and that all blank spaces have been either completed or crossed off prior to my signing.

I do NOT wish to proceed with the recommended treatment/procedure.

Signature of refusing patient: _____ Date: _____ Time:_____ ☐ AM ☐ PM

Signature of refusing party, if other than the patient: _____ Date: _____

Relationship to patient: _____

Signature of the physician/provider: _____ Date: _____

Signature of witness: _____ Date: _____

This sample form is for illustrative purposes only. Your clinical treatments/procedures and risks may be different from those described, We encourage you to modify this form to suit individual needs of your healthcare setting and patients. As each setting presents unique situations and statutes may vary by state, we recommend that you consult with your attorney prior to use of this or similar forms in your healthcare setting.