INFORMED REFUSAL TO CONSENT TO TESTING, PROCEDURES AND/OR MEDICAL TREATMENT

I UNDERSTAND AND ACKNOWLEDGE THAT MY PHYSICIAN ___________________________ HAS RECOMMENDED THE FOLLOWING TESTS/PROCEDURES/TREATMENT:

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I HAVE BEEN EXPLAINED THE POTENTIAL BENEFITS OF THE ABOVE INCLUDE:

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I HAVE BEEN EXPLAINED THE POSSIBLE RISKS OF THE ABOVE INCLUDE:

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I UNDERSTAND THAT BY REFUSING TO HAVE THE TEST/PROCEDURE/TREATMENT, I COULD HAVE FURTHER COMPLICATIONS INCLUDING, BUT NOT LIMITED TO THE FOLLOWING:

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I UNDERSTAND AND ACKNOWLEDGE THAT MY PHYSICIAN RECOMMENDS THE TEST/PROCEDURE/TREATMENT AS OUTLINED ABOVE, HOWEVER, I DECLINE TO CONSENT TO THE TEST/PROCEDURE/TREATMENT AT THIS TIME. FURTHER, MY PHYSICIAN HAS EXPLAINED THE BENEFITS AND RISKS OF THE TEST/PROCEDURE/TREATMENT, AS WELL AS THE RISKS ASSOCIATED WITH NOT HAVING THE TEST/PROCEDURE/TREATMENT.

BY SIGNING THIS REFUSAL, I UNDERSTAND AND ACKNOWLEDGE THAT I AM MAKING AN INFORMED DECISION UPON MY OWN FREE WILL, AND THAT I AM COMPETENT TO MAKE SUCH A DECISION AT THIS TIME.. I HAVE ALSO HAD AN OPPORTUNITY TO DISCUSS ALL OF THE RISKS/BENEFITS AND ANY OTHER CONCERNS WITH MY PHYSICIAN; AND UNDERSTANDING ALL OF THE ABOVE, I CONTINUE TO REFUSE TO CONSENT TO THE TEST/PROCEDURE/TREATMENT.

___________________________________	___________________________________
Patient or Legal Representative Signature/Date/Time	Relationship to Patient
___________________________________	___________________________________
Print Patient or Legal Representative Name	Witness Signature/Date/Time