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REFUSAL OF RECOMMENDED MEDICAL OR SURGICAL PROCEDURE/INTERVENTION

Patient Name: _____

The following has been explained to me by:_____**(Physician)**

That I have the following condition(s): _____

_____

That the following procedure/intervention has been recommended: _____

_____

The nature of the recommended treatment: _____

_____

The purpose of and need for the recommended treatment: _____

_____

The possible alternative(s) to the recommended procedure or intervention for which I refuse consent: _____

_____

The nature and likelihood of the consequences of not proceeding with the recommended procedure/intervention or the above described alternative(s): _____

_____

I understand that my failure to accept the recommended procedure/intervention may endanger my life or health; I nonetheless refuse to consent to it.

My reason for refusal is: _____

_____

_____

X _____ _____
Patient (or person authorized to sign for patient) Date

X _____ _____
Witness Date