INFORMED REFUSAL OF TREATMENT

I have been informed by Dr. _____ of my condition and the recommended treatment consisting of _____

_____

The clinical indications for this course of treatment are _____

_____

_____

_____

I have also been offered alternative treatments which include _____

_____

_____

It is the opinion of the doctor(s) treating me that this procedure is medically necessary and that the potential risks and complications of not following this course of treatment are _____

_____

_____

_____

After considering all treatment possibilities with the doctor and having the risks and benefits of each explained to my satisfaction, I have voluntarily chosen to _____

_____

_____

_____

I understand that my decision is contrary to the recommended course of treatment and that my condition may significantly worsen as a result, and/or require additional therapy and/or hospitalization, and in rare circumstances may be life-threatening. I AGREE TO RETURN FOR PERIODIC MONITORING AS SCHEDULED BY THE DOCTOR AND UNDERSTAND THAT I MAY RECONSIDER MY DECISION AT ANY TIME.

_____ _____

Patient's (or legal guardian's) signature Date

_____ _____

Witness' signature Date

_____ _____

Doctor's signature Date