PATIENT REFUSAL OF TREATMENT FORM

DATE:

MRN:

NAME:

Treatment refused against doctor's advice:

1. ☐ I refuse to stay in the hospital
2. ☐ I refuse the following treatment, test or procedure:

   ____

3. ☐ I refuse a blood or blood product transfusion

The doctor talked to me before I signed this form. The doctor explained my (the patient's) medical-surgical condition.

I have been told that in the doctor's judgment the recommended treatment is necessary to treat my (the patient's) present condition.

The doctor also explained the possible result and complications, including death, of my (the patient's) refusal.

The doctor also explained that I can go to the emergency room as needed.

I have read and/or have had read to me the above **<u>Patient Refusal of Treatment Form</u>** and I understand what it means.

SAMPLE

______________________________ ______________

Patient/Legal Guardian Signature Date/Time

______________________________ ______________

Provider Signature Date/Time

White Copy - MEDICAL RECORDS Yellow - PATIENT

FORM #: HFHS-34-3208MR-0509