REFUSAL OF TREATMENT FORM

Date: _____________________
Client Name: ___________________________

______________________________

(Health professional) ________________________ has recommended that I undergo the following test/treatment/procedure:

______________________________

I acknowledge the following (please tick all that apply):

☐ My medical condition has been explained to me by a health professional and/or my key worker
☐ The reason for and/or purpose of the recommended test/treatment/procedure have been explained to me
☐ The nature of the recommended test/treatment procedure has been explained to me
☐ The risks and benefits of the recommended test/treatment/procedure have been explained to me
☐ All of my questions about the recommended tests/treatment/procedure have been answered
☐ I have been advised by paramedics to attend hospital

The risks of refusing the recommended test/treatment/procedure/hospital attendance have been explained to me. They include but are not limited to:

Potential delay in diagnosis and treatment of health conditions.

I also understand there could be risks of refusing the recommended test/treatment/procedure/hospital attendance that are not known yet. Although my refusal to follow ______________________ (insert name of health professional here) advice and undergo the recommended test/treatment/procedure/hospital attendance could seriously impair my health or even result in death. I choose to refuse the recommended test/procedure/treatment and accept the risks and consequences of my decision. I understand that I could change this decision at any time by contacting ______________________________ and taking action to cancel this refusal.

Patient signature: _______________________________ Date: _______________________
Patient name (printed): ___________________________ Date: _______________________
Staff Signature: ________________________________ Date: _______________________
Health professional signature (if present) ________________________________