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) _____