INFORMED REFUSAL OF TREATMENT

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

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The clinical indications for this course of treatment are _______________________________________

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I have also been offered alternative treatments which include __________________________________

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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 _____________________

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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 _______________________________________

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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